Forever Hope Counseling & Educational Services, LLC

Stone Oak Location
1162 E. Sonterra Blvd, Ste 130
San Antonio, Texas 78258

Boerne
108 Oak Park
Boerne, TX 78006

AUTHORIZATION TO DISCLOSE MENTAL HEALTH INFORMATION

I hereby authorize Forever Hope Counseling & Educational Services, LLC to disclose the individually identifiable health information as described below, which may include psychotherapy notes. I understand that this authorization is voluntary, and I may refuse to sign this authorization. I also understand that if I do not sign this form, federal and state law will prohibit Forever Hope Counseling & Educational Services, LLC from releasing records regarding his/her treatment of me/my child to the designated Recipient. I understand that if the recipient is authorized to receive the information is not a covered entity, e.g. insurance company or health care provider, the released information may no longer be protected by federal and state privacy regulations.

Print Patient Name: _____ *DOB:* _____

Address: _____

Description of information to be released: (check all that apply)

____ Treatment Plan
____ Progress Notes
____ Billing
____ Diagnostic Testing
____ Other:
_____

Description of the purpose of the use and/or disclosure: _____

_____

The individually identifiable health information described above shall be shared with:

Print Name: _____ *Phone Number:* _____

Address of recipient: _____

I intend for this Authorization to remain in full force and effect until I revoke it in writing. Further, it is my intent that a copy of this Authorization shall have the same effect as the original.

I further understand that I may revoke this authorization at any time by notifying Forever Hope Counseling & Educational Services, LLC in writing at 1162 E. Sonterra Blvd, Suite 130, San Antonio, TX 78258. I also understand that the written revocation must be signed and dated with a date that is late than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Client/Guardian Signature: _____ Date: _____

Print Name of Client/Guardian: _____ Relationship to client: _____

Or

Print Name of Legal Authority (attach supporting documentation): _____

Clinicians or office staff are not permitted to speak to your attorneys with this form. All legal representatives must secure a subpoena to speak with a member of our practice. See our client agreement for associated fees for communicating with attorneys and related court retainer fees.