HeartLife Professional Soul-Care
7947 Players Forest Drive
Suite 103
Memphis, TN 38119

AUTHORIZATION FOR RELEASE OF INFORMATION

Pursuant to Federal Law and/or Privacy Act concerning my (our) right to confidentiality, I (we),

____

Names of Counselee   Social Security Number   Date(s) of Birth

I Authorize HeartLife Professional Soul Care and ______________________________ (name of HeartLife counselor/psychologist) to disclose and furnish my (our) counseling and health information to:

____

(Name and address of specific person or organization receiving records and information)

I (we) specifically authorize the disclosure and release of any and all counseling and health information and records pertaining to my (our) evaluation and treatment with the above named counselor/psychologist. The Primary Purpose for this disclosure is for overall treatment planning or referral. The other purpose of the release of this information is *(state on line below if specification is needed)*:

____

(Specific information to be released if specific conditions apply)

I understand that the information to be disclosed may include information relating to diagnosis and/or treatment for psychological, psychiatric or mental illness, alcohol abuse, drug abuse, and Human Immunodeficiency Virus (HIV), AIDS virus, and life-threatening communicable disease(s).

I (we) understand that I (we) may revoke this authorization at any time in writing delivered to HeartLife. I (we) understand that any release of information which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my (our) right to confidentiality. I also understand that any disclosure carries with it the potential for re-disclosure by the recipient of the information and such re-disclosure may not be protected by federal confidentiality laws.

Unless I (we) revoke this authorization prior to such time, this authorization shall expire:
CHECK ONE: _____ one (1) year after my (our) last visit with the above named
_____ one (1) year from the date of signature below
(at which time no expressed revocation shall be needed to terminate my [our] consent)

I (we) understand this authorization is voluntary and I may refuse to sign this authorization. Unless allowed by law, my refusal will not affect the receipt of treatment.

______________________________   ______________________________
Counselee(s) Signature   Witness

____
Date

If the counselee is a minor or has a guardian appointed by the court, this release must be signed by the counselee's parent or guardian.

______________________________   ______________________________
Parent or Guardian   Witness

____
Date