

Hinman Counseling Services
Authorization to Release Information

640 St Joseph Ave
Berrien Springs, MI 49103
(269) 471-5968

Client information

Client name: _____

Date of birth: _____

Treating counselor: _____

I authorize Hinman Counseling Services to disclose the information specified below to the following person or organization:

Name: _____

Organization, if applicable: _____

Address: _____

Phone: _____ Fax: _____

Describe the specific information that may be shared. Only the information identified here is authorized for release.

Dates of care covered by this authorization:

From: _____ To: _____

This authorization does not include separately maintained psychotherapy notes. Those require a separate authorization. **Reason for sharing this information:**

Expiration date or event: _____

Signing this authorization is voluntary. Hinman Counseling Services will not condition your counseling treatment or payment for treatment on whether you sign this form.

You may revoke this authorization at any time by delivering a written request to Hinman Counseling Services at the address above. Revocation takes effect when HCS receives your request. It does not undo disclosures or other actions already taken in reliance on this authorization.

You should know that information disclosed to the recipient may be shared again by the recipient without your or HCS's consent and may no longer be protected by the HIPAA Privacy Rule.

You have the right to receive a copy of this signed authorization.

I have read and understand this form. I authorize the release of the information specified above.

Client or authorized representative signature:

Date: _____

Printed name: _____

If signing on behalf of the client, describe your legal authority to act for the client:
