Harvest Counseling

Glen Keeffe MA, LMHC

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient_____ Date of Birth: _____
Dates of Therapy: _____

PERSON(S) STRENGTH OF LIFE IS ALLOWED TO RELEASE INFORMATION TO:

Name:_____
Relationship to Patient: _____

I SPECIFICALLY AUTHORIZE STRENGTH OF LIFE COUNSELING TO RELEASE THE FOLLOWING:

_____Appointment Dates and Time
_____ Appointment Scheduling
_____ Payment Information
_____ Insurance/Insurance Billing Information
_____ Information for Family Member/Spouse at Clinician's Discretion
_____Other_____

I hereby release Harvest Counseling Services from any liability which may arise as a result of the use of the information contained in the copies of records hereby released and it will be presumed that if such information is later used to my damage it was obtained as a result of this authorization.

_____	_____	_____
Signature of Witness	Signature of Client	Date
_____	_____	_____
Signature of Witness	Signature of Parent/Guardian	Date

PROHIBITION OF REDISCLOSURE

This *information has been disclosed to you from records protected by Federal Law. Federal Regulations prohibit making any further disclosure of the information unless expressly permitted in writing by the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for release of information is NOT sufficient for this purpose.*