Lighthouse Counseling Center PC
121 Jackson Street, Newnan, GA 30263
Phone: (770) 251-5873 Fax: (770) 304-2201

Authorization Form

(Effective 9/18/13)

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize my therapist, _____ and/or administrative and clinical staff to release:

	History		MMPI Profile		Psychological Reports
	Progress Notes		Verbal Communication		Discharge Summary
	Psychological Test Results		Written Communication		Other (See Below)

Other: (your description should be as specific and detailed as possible):

_____

This information should be released to and /or received from (name and address of person to whom the information is to be released and/or received)

Name: _____

Business: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

I am requesting my therapist to release this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)
___***at the request of the individual***_____

_____

This authorization shall remain in effect for **1 year** from signature date or until I provide written notice.
You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.
I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Client Signature Date
(Legal Guardian if under 18 and relationship to client)

_____
Print Client's Name DOB

_____
If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

_____
Witness