THE BALANCING BAR
COUNSELING & PSYCHOTHERAPY

AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

Authorization for the use and disclosure of Protected Health Information (PHI) is only for the person or agency on this form. No responsibility can be accepted if it is made available to any other person or agency. Any duplication, transmittal, re-disclosure, orre-transfer of information is expressly prohibited.

I,_____, whose Date of Birth is_____authorize **The Balancing Bar, LLC and Charkela Jenea Gaston Molden** .whose main office is **Macon, Georgia 31216** to release/exchange by phone, fax, or mail confidential information about my health treatment/services (including mental health services with the persons/agencies listed below.

With:_____

_____

(Name/Address of person/organization to which disclosure is to be

TO PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Title 45 (Code of Federal Rules of Privacy of Individually Identifiable Health Information Parts 160 and 164) and Title 42 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus state laws prohibit you from making any further disclosure without the specific written consent of the person to whom it pertains, or otherwise permitted by such regulations. A general authorization for the release of information is not sufficient for this purpose FOR CLIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2

I, the undersigned, understand that a copy of this signed authorization form is as acceptable as the

The protected health information to be disclosed includes the following:

___Assessment Information
___Diagnosis
___Treatment Planning Notes
___Progress & Treatment Notes
___Medication
Other (please specify) _____

___Psychiatric Evaluation
___Results of Psychological Testing
___Recommendations
___Reason for Termination
___Number of kept/Unkept Appointments

For the purpose of: Continued Care; Education; Legal; Insurance; Collaboration; Other: _____

Dates of records to be released: _____

This release will expire: ___at the end of 1 year from the date of signature

___ at the termination of treatment

___ as of _____

(Specify Date)

I understand that I may revoke this authorization at any time to the extent that action has been taken in reliance on it. I acknowledge that this authorization is voluntary and that payment or eligibility for benefits for my health care will not be affected if I do not sign this form. I also understand that the information disclosed as a result of this authorization may no longer be protected by privacy laws and may be disclosed by the company or individual receiving the information.

Client's Name (printed) _____ Date _____

Signature of Parent, Guardian or Personal Representative_____ Date _____

Signature of Staff Witness _____ Date _____