CARMEL COUNSELING CENTER

1145 Pineville-Matthews Rd., Matthews, NC 28105
Phone 704.849.0686 Fax 704.815.1972

Client Consent for Release of Information

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand the contents to be released and the need for that information.

Client Name: _____ DOB: _____

Signature of Client or Legal Guardian (if client is under 18):

_____

Date: _____

I hereby authorize:

_____ at Carmel Counseling Center
(counselor's name) 1145 Pineville-Matthews Road
Matthews, NC 28105 (704) 849.0686

To release and exchange specified information in my client record to:

Name: _____

Address: _____

City, State, Zip Code: _____

Telephone: _____Fax: _____

Description of the specific information to be used or disclosed:

□ Verbal or written summary of psychotherapy sessions
□ Psychological testing
□ Assessment
□ Treatment plans with diagnosis
□ Recommendations
□ Progress Reports
□ Other _____

This authorization shall remain in effect until _____ (expiration date)