AUTHORIZATION FOR RELEASE OF MENTAL HEALTH AND OTHER PERSONAL HEALTH INFORMATION FOR SCHOOL-BASED SERVICES

I, ____ hereby authorize Clearhope Counseling & Wellness Center, PC
(Patient/Parent/Guardian/Power of Attorney)

to exchange/release information regarding ____.
(Name of Student)

The following items must be **checked** to be included in the use and/or disclosure of other health information:

☐ Date(s) of service ☐ Student's Name ☐ Therapist's Name

☐ Place of Service ☐ Educational Needs ☐ Therapist's Educational/Behavioral Recommendations

to ____
(receiving School/person) (Address)

for the purpose of (please check all that apply):

☐ Educational Collaboration/Recommendations/Support

☐ Billing, payment and financial matters and arrangements

☐ Other ____________________________________

This consent is valid until (calendar date) ____

I understand that I have the right to inspect and copy the information to be disclosed and may revoke this authorization at any time. Any such revocation will not affect materials disclosed prior to the revocation. The above-named person/school/entity authorized to receive this information may use the information only for the purposes outlined above and may not redisclosed it without my written authorization.

____ _____________________________________
(Minor recipient, 14-17 yrs. Inclusive) (Signature of parent)

____
(Witness)

NOTICE TO PATIENT AND RECEIVING AGENCY:

Under the provisions of HIPPA and applicable Federal and State Confidentiality Acts, there may not be redisclosure of any of the information provided pursuant to this release unless the patient, and/or parent of the patient who is a minor, specifically authorizes such disclosure. A separate release is required for psychotherapy notes.

REVOCATION OF AUTHORIZATION: The undersigned hereby revokes the above authorization for disclosure.

____ ____
(Patient, parent, guardian) (Witness)

____ ____
(Authorized agent - Power of attorney attached) (Date)