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AUTHORIZATION FORM

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 Counselor, Marty Glass, LPC and/or his administrative and clinical staff, to speak to and/or release information, knowledge, data, treatment prognosis and/or results. This information should only be released to (name and address of person to whom the information is to be released.) ______________________________

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This authorization shall remain in effect until ____________________.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, 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 information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

________________________________ ______________
Signature of Patient/Guardian Date

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If a personal representative of the patient signs the authorization, a description of such representative's authority to act for the patient must be provided