Inspiring Hope Counseling Services, LLC

Chaute Thompson, LMHC
2440 SE Federal Hwy Suite Y Stuart, Florida 34950 772.302.6191

Instructions: Please fill out the form completely. All clients seen in the counseling room with the client whose records are being requested will need to fill out this form in order for this authorization to be valid. *Please **initial** all boxes you would like to authorize.*

Authorization for Release/Exchange of Information

Name: _____
DOB: _____ SSN: _____

I, _____, hereby request and authorize:

_____
(Name of person(s) or agency you'd like Chaute Thompson, LMHC to interact with)

_____
Address

_____(_____)_____(_____)_____
City State Zip Code Phone Fax

to ☐release or ☐exchange medical, education, mental health, or other pertinent information from my record with Chaute Thompson, LMHC, at 2440 SE Federal Hwy Suite Y Stuart, Florida 34994 Phone: 772.302.6191 for the purpose of best practices and/or continuity of care of: _____ _____ (the client who's record this authorization pertains to).

The specific information to be disclosed is:

☐Psychiatric treatment, evaluation(s) and record(s)
☐Psychological testing and evaluations
☐Inpatient or Outpatient Treatment Records
☐Mental health/Counseling records/information
☐Substance use, history and treatment records
☐Education records, testing data, & information
☐Medical information
☐Rehabilitation records
☐Police report(s)
☐Legal information/Court order
☐Verbal communication about checked items
☐Other: _____

I understand this authorization is voluntary and will automatically be revoked twelve (12) months from the date of the signature, or upon termination of treatment if less than twelve (12) months from the date of signature. I understand that I have the right to refuse to sign this authorization without penalty. I further understand that I have the privilege of revoking authorization at any time, provided that I provide written notice. However, this revocation will not affect information released prior to the written revocation. This release shall be in compliance with federal regulations (42 CFR, part 2, Section 33 of Public Law 910616 as amended by Public Law 93-282) and will comply with all applicable state and local laws, rules, and regulations.

_____ _____
Signature of Client Date Signature of Witness Date

_____
Signature of Parent/Legal Guardian Date

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further re-disclosure is strictly prohibited. Florida Law requires that any person, agency, or entity receiving information shall maintain such information as confidential and exempt from the provisions of the public records law.