Whole Hope Christian Counseling, LLC_____

Individual, Couple, and Family Counseling
Mediation and Conciliation

HIPAA Release for Assessment and Treatment

**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

I, the undersigned, am requesting counseling and / or consultation services by

Whole Hope Christian Counseling, LLC *(EIN: 81-4201353)*

This authorizes Whole Hope Christian Counseling and those there under, to provide consultation, counsel and referral services. I have been informed of the nature and purposes of this service, and that my consent can be revoked in writing prior to, and/or during the consultation period.

I have read and fully understand the above authorization for counseling/ consultation. No guarantee of assurance has been made to me as to any of the results that may be obtained from these services. This is a release of any and all liability to Whole Hope Christian Counseling and those under the practice from any decisions or actions that I may or may not take as a result of the counseling I receive from this practice.

I authorize _____ to use and disclose the protected health information described below to Whole Hope Christian Counseling, LLC.

This authorization for release of information covers the period of healthcare from: _____to _____or all past, present and future periods. Please mark with an X: _____

Extent of Authorization - Client must initial next to box if checked.

a. □ I authorize the release of my complete health record (including records relating to mental health care, communicable diseases, and treatment of alcohol or drug abuse).

OR

b. □ I authorize the release of my complete health record with the exception of the following information:
   - □ Mental health records
   - □ Communicable diseases (including HIV and AIDS)
   - □ Alcohol/drug abuse treatment
   - □ Other (please specify): _____

1. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
2. I understand that I have the right to revoke this authorization in writing at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
3. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
4. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Client's Signature:_____

Signature of Parent or Guardian if client is under 18:_____

Staff Signature:_____

FURTHERMORE, I have received a copy of this contract and have read the HIPAA policy as required by law.

Client's Signature:_____

Signature of Parent or Guardian if client is under 18:_____

Date:_____