AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the release of information between (*to and/or from*):

C.L. Bockwitz, LPC, CPCS, RPT-S
558 Medlock Rd. Suite A
Decatur, GA 30030 &
404.702.2007 (vm)
404.541.4690 (fax)

Person/Agency:_____
Address:_____
_____
Phone: _____**Fax:**_____
Email contact:_____

To disclose records and/or information concerning: Client:_____
Date of Birth:

for the following purpose(s):

___Assessment/Diagnosis
___Consultation/Treatment Review
___Outpatient Treatment Summary
___Hospital Admission/Discharge Summaries
___Results of Psychological Testing/Screening Assessments
___Other:

Exchange of information is requested for the following purpose(s):

___Referral To/From_____
___Collateral Contact for Information
___Coordination of Treatment and Services
___Other:

HIPAA PRIVACY STATEMENT

In accordance with federal HIPAA regulations, I am required to include this disclosure statement in this report. This information has been disclosed to you, the confidentiality of which is protected by Georgia law. The HIPAA regulations prohibit making any further disclosure of the information without the specific written consent of the Court or the person (or legal guardian) to whom it pertains or as otherwise permitted by regulations governing therapists. A general authorization for the release of medical or other information is not sufficient for this purpose. This report is strictly confidential and is intended to provide information only for the person to whom it is addressed. No responsibility can be accepted if it is made available to any other agency, insurance carrier, or person, including the patient. This Notice is in effect April 14, 2003.

You have the right to revoke this authorization at any time, unless the Provider(s) noted above has already acted on the authorization. Any revocation must be in writing and received by C.L. Bockwitz at the address indicated above. This authorization lasts for one year after the date of your signature unless you enter a different date or expiration here: _____.

Signed:_____ Date: _____
Parent or Legal Guardian (print) and (sign)

Witness:_____ Date:_____
C.L. Bockwitz, LPC, CPCS, RPT-S