Metropolitan Counseling Services
2801 Buford Hwy, NE Suite 470
Atlanta, Georgia 30329
Phone: (404) 321-1794
Fax: (404) 321-1928

RELEASE OF PROTECTED INFORMATION

Client Name_____
Please Print

This form authorizes your therapist to ***release and obtain*** protected information from your clinical records with the designated person below.

I authorize my therapist_____

to release and obtain protected information from my clinical records from

Name_____

Address_____

_____

Phone_____

Fax_____

For the purposes of

_____Diagnostic assessment
_____Treatment coordination
_____Treatment planning
_____Treatment summary and diagnosis
_____Medication consultation
_____Other
_____
_____

This authorization shall remain in effect until
_____Date of expiration
_____Date of termination
_____No expiration at this time

I understand that I have the right to revoke this authorization in writing at any time by sending written notification to Metropolitan Counseling Services, 2801 Buford Hwy, Suite 470, Atlanta, Georgia, 30329.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Client Date