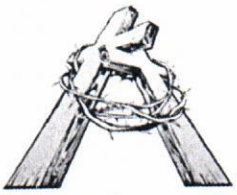

Awakenings
Christian Counseling

4250 S. Westnedge Kalamazoo MI 49008
Email: counsel@awakeningscc.com Phone: 269-234-2343

Release of Information Authorization

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

CLIENT: _____ DOB: _____

I authorize my therapist at Awakenings Christian Counseling to release the following information from my personal health information:

□ Entire Clinical Chart □ Initial Diagnostic Impressions □ Treatment Plan

□ Psychological Report □ Therapeutic Notes □ Discharge Summary

□ Medical Information □ Educational Information □ Legal Information

□ Other _____

I am requesting my therapist to:

□ Release Information □ Gather Information □ Reciprocally Exchange Info

TO: _____

_____

□ Upon Request □ To Facilitate/Coordinate Care □ Other _____

This Authorization shall remain in effect until:

□ One (1) year from the date of signing □ One time release □ Until _____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to Awakenings Christian Counseling. However, your 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 gathering insurance coverage and the insurer has a legal right to contest a claim.

I understand that my therapist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to the client for the purpose of facilitating health information for a third party.

Further, 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 Client Date

_____ _____
Parent or Guardian Signature Date

_____ _____
Witness Signature Date