Core Discovery Counseling, Inc.
Kim Morrow Taff, EdS, LPC
2964 Peachtree Road NW, Suite 620
Atlanta, GA 30305
404.419.6082

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 to

Name_____

Address_____

_____

Phone_____

Fax_____

For the purposes of:

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

Information shall be limited to

_____

_____

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 Core Discovery Counseling, Inc., 2964 Peachtree Rd NW Ste 620 Atlanta GA 30305.

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