Affinity Counseling Center

Authorization For Release Of Information

Name of Client_____ **Date of Birth**_____

Medicaid# _____ **ID#** _____ (if non Medicaid)

I hereby request and authorize:

Affinity Counseling Center, LLC, its agents, representatives, and/or clinical staff

To obtain from ☐ **and/or release to** ☐

Name of Person / Agency: Address:

The following type of information from my records (and any specific portion thereof) for the purpose of continued care:

- ☐ Treatment Plans
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Social/Developmental History
- ☐ Psychiatric/Psychological Evaluations
- ☐ Education Reports
- ☐ Health/Medical Records
- ☐ Education/School Reports (grades, conduct, attendance, IEP)
- ☐ Probation Report/Court Orders
- ☐ Other _____

I understand that the federal Privacy Rule (HIPAA) does not protect the privacy of information if re-disclosed and therefore request that all information obtained from this person or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for benefits, treatment or payment is not conditioned upon my provision of this authorization. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effect for:

- ☐ Ninety (90) days
- ☐ One (1) year
- ☐ The period necessary to complete all transactions related to services provided to me.

_____ _____

Signature of Client/Parent/Legal Guardian Signature of Witness/Title or Relationship

_____ _____

Date Date

Use this space only if client withdraws consent

_____ _____

Date Consent is Revoked by Client Signature of Client/Parent/Legal Guardian

Affinity Counseling Center, LLC
3883 Rogers Bridge Road, NW, Suite 204A, Duluth, GA 30097
Office: 678-392-1302 Fax: 877-505-5278 www.valuelives.com