PROTEA
COUNSELING & CONSULTATION GROUP, PLLC

5500 Poplar Avenue
Suite 11
Memphis, TN 38119

Consent & Authorization to Disclose, Exchange and Use Information and Records

Client Name: _____ Date of Birth: _____

I hereby authorize Protea Counseling & Consultation Group, PLLC. and the agency/entity or person listed below, to use, disclose, and exchange information about me and/or the child listed above for the purpose of collaborating, coordinating, and facilitating services and treatment.

Name of Individual/Entity: _____

Contact Information: _____

I authorize the release, disclosure and exchange of health information as follows:

- ☐ Name and other personal identifying information
- ☐ Evaluations/Assessment of Status/Progress Reports
- ☐ Summaries of history, treatment, and outcomes
- ☐ Plans of Care and Treatment Plans
- ☐ _____

I understand:

- My right to refuse to sign this authorization
- I understand this authorization is effective immediately and subject to revocation at any time for any reason except to the extent it has already been taken. If not revoked early, this authorization will be revoked after 365 days or upon discharge from Protea Counseling & Consultation Group, PLLC.
- My records are protected under state and federal laws governing confidential healthcare information, including the Health Insurance Portability Act of 1996 (HIPAA). These records cannot be released without my authorization unless otherwise by state and federal regulations.
- Information disclosed pursuant to this authorization may be subject to re-disclosure by a recipient of such information. It is possible that once disclosed, the confidentiality of this information may no longer be protected by the state and federal privacy laws.
- I may revoke this authorization at any time in writing to the Director of Protea Counseling & Consultation Group, PLLC.

_____ ___/___/____ _____ __/___/____

Signature of Client (if 14 or older) Date Signature of Parent/Guardian Date

_____ ___/___/____

Signature of Staff Member