

Agape Psychological Consortium, PLLC
 Ethical, Compassionate, and Competent Services
 for Children, Adults, & Families
 (336) 855 - 4649

Individual, Couple & Family Therapy
 Emotional & Behavioral Diagnostic/Treatment Services
 Clinical & Educational Consultation/Advocacy

Psychological & Intellectual Assessment
 ADHD & Learning Disability Evaluation
 Court Related & Mandated Services

AUTHORIZATION FOR THE DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

Client's Name: _____ DOB: _____

Recipient Program/Person's Name: _____ Phone #: _____

Address (if known): _____

I hereby authorize the above-named person/program and Agape Psychological Consortium to share the specified information in my, or minor child's, record. *The released data shall include:*

Psychological Evaluation		Medication Information		Service Recommendations	
Psychiatric Evaluation		Alcohol/Drug Treatment		Termination Summary	
Diagnosis		Intake Information		Educational Information	
Service Plan		Progress/Session Notes		Summary of Eval. / Treatment	
Other/Disclosures made regarding...					

The above information will be used for the following purposes:

- Planning appropriate treatment or program
- Determining eligibility for benefits or program
- Updating files
- Continuing appropriate treatment or program
- Case review
- Other (specify)

I hereby acknowledge that Agape Psychological Consortium has not conditioned my treatment on signing this authorization, and that I may refuse to sign this authorization if I so desire. I also recognize that I retain the right to revoke this authorization except to the extent that the agency has already taken action in reliance on the consent. Once information is disclosed pursuant to this signed authorization, I understand that the HIPAA privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information, and therefore, may not prohibit the recipient from disclosing it. Other laws, however, may prohibit disclosure. Upon disclosure of mental health and developmental disabilities information protected by state law (G.S. 122-C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), this organization informs the recipient of the information that re-disclosure is prohibited except as permitted or required by these two laws.

If not revoked earlier, this authorization expires automatically on _____ or one year from the date it is signed, whichever is earlier. I HAVE READ THIS INFORMATION AND UNDERSTAND THAT THERE ARE STATUTES AND REGULATIONS PROTECTING THE CONFIDENTIALITY OF AUTHORIZED INFORMATION. I HEREBY ACKNOWLEDGE THAT THIS AUTHORIZATION IS TRULY VOLUNTARY AND THAT I AM THE PROTECTED CLIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE CLIENT TO SIGN THIS DOCUMENT. I FULLY AGREE WITH THE ABOVE STATED TERMS. I UNDERSTAND THAT I MAY REQUEST A COPY OF THIS AUTHORIZATION ONCE IT HAS BEEN SIGNED.

 Client and/or Legally Responsible Person

 Witness (not required) Relationship to Client Date

 Interpreter for Client (if necessary) Date