Agape Psychological Consortium, PLLC
Ethical, Compassionate, and Competent Services

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Individual, Couple & Family Therapy
Emotionally & Behaviorally Disruptive Treatment
Clinical & Educational Consultation
Psychological & Intellectual Assessment
ADHD, LD & Other Diagnostic Evaluations
Court Related & Mandated Services

AUTHORIZATION FOR THE DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

Client's Name: _____

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

Address (if known): _____

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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 recipient/person shall include:*

School System		*Primary Care Provider*		*Psychiatrist/Physician*	
Psychologist/Therapist		*Employer*		*DSS/DJJ*	
MCO		*Other (Specify):*			

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.

_____ and/or _____
Client — Legally Responsible Person

_____ _____ _____
Witness *(not required)* — Relationship to Client — Date

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Revised: 01/18