Grow Yourself Great Counseling and Consulting, PLLC

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Charlotte, North Carolina 28269

Consumer's Name:	**Date of Birth:**	**Record #:**
Legal Guardian:	**Insurance:**	**Policy #:**

RELEASE OF INFORMATION

Authorization for Use and Disclosure of Protected Health Information

I,____________________________(Consumer / Guardian), authorize GYG Counseling & Consulting PLLC to disclose private health information to ____
Agency or Person to whom the requested use or disclosure will be made effective on the date of my signature.)

Reason for information to be released: *continuity of care* ____
____

I consent to the release of information or records created by or disclosed to GYG Counseling & Consulting PLLC pertaining to:

_______ Person Centered Plans / Treatment plans
_______ Crisis Plan
_______ Service Notes / Reports/ Updates
_______ School Records
_______ Psychological Reports
_______ Immunization/Medical Reports
_______ Other (Please be ____
____

_______ Assessments
_______ Admission/Intake Information
_______ Discharge Information
_______ Guardianship Paperwork
_______ Written & verbal communications pertinent to Tr

Please initial the lines below

________ I understand that the information disclosed may have been created by GYG Counseling & Consulting PLLC or released to GYG Counseling & Consulting PLLC by other agencies (i.e. re-release)

________ I understand this is a full release and that information disclosed regarding my treatment may include (if applicable) information pertaining to psychiatric or psychological treatment, drug abuse and/or alcohol abuse, or Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) in compliance with 42 CFR Part 2 and will be confidential and disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section..

________ I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand that GYG Counseling & Consulting PLLC cannot deny or refuse to provide services.

________ I understand that, with certain exceptions, I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing.

If not revoked earlier, this authorization expires on: ____________________________________ (date) **not to exceed one year of signature**.

Consumer's Signature: ______________________________________ **Date:** __________

Legal Guardian's Signature: __________________________________ **Date:** __________

GYG Staff's Signature: ______________________________________ **Date:** __________