STONE & IVY
RELATIONSHIP COUNSELING

AUTHORIZATION TO RELEASE or EXCHANGE INFORMATION

I, **(name of client)** _____, ("Client") hereby authorize **Stone & Ivy Relationship Counseling, PLLC,** ("Stone & Ivy), and my provider, Leah Travis, MS, LMFT, ("Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Client, including, but not limited to, therapist's diagnosis of Client, to:

_____
Name of person/school/business/agency

_____ _____
Phone Email

_____
Address

_____ **(Initial if applicable)** I also authorize the above-named individual or entity to disclose information with Stone & Ivy and my Provider.

I am requesting this disclosure of information and records for the following purpose:

- ☐ At the request of the Client
- ☐ Other **(be as specific as you choose to):** _____

The specific uses and limitations of the types of medical information to be discussed are as follows **(be as specific as you choose to)**:

- ☐ Treatment Coordination ☐ History & Diagnosis ☐ Billing ☐ Scheduling
- ☐ Other **(be as specific as you choose to):** _____

Such disclosure shall be limited to the following specific types of information **(be as specific as you choose to)**:

- ☐ Full Treatment Record ☐ Treatment Summary ☐ Treatment Plan
- ☐ Dates of Treatment ☐ Psychiatric Diagnoses ☐ Account Balance
- ☐ Other **(be as specific as you choose to):** _____

I understand that I have a right to receive a copy of this authorization.

I understand that my Therapist generally may not condition treatment upon signing this authorization, unless the services are provided to me for the purpose of creating health information for a third party. I understand that I have the right to refuse to sign this form.

I understand that I have the right to revoke or modify this authorization at any time, except that it cannot be modified or revoked retroactively, and requests to cancel or modify do not impact actions my Provider has taken in reliance upon it. I also understand that such revocation must be in writing and is not effective until received by Provider.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable North Carolina law may protect such information.

This authorization shall remain valid until (date or event): _____ (Not to exceed 1 year.)

_____ _____
Signature Date