Horizons Counseling Services, Inc., 5851 Pearl Rd., Ste. 305, Parma Heights., OH 44130
440-845-9011; fax- 440-845-9013

Authorization to Release Information

Name _____ Date of Birth _____

___ I authorize _____ and Horizons Counseling Services to release to the person or organization designated in the box below, the following information: _____

_____

___ I authorize the person or organization designated in the box below to release to _____ and Horizons Counseling Services the following information: _____

_____

Name _____
Address _____
City, State _____ ZIP: _____
Phone: _____ Fax: _____

I am requesting that this information be released for the following reason(s):

___ Coordination of Treatment ___ Information for Assessment ___ At my request

___ Other: _____

This authorization shall remain in effect until:

___ Evaluation and/or treatment are completed ___ This date: _____

___ Other (specify): _____

I understand that I have the right to cancel this authorization by sending written notification to Horizons Counseling Services and/or the party named above. However, I understand my cancellation will not be effective to the extent that Horizons has already taken action regarding the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that the recipient of this information may re-disclose it and that the information will no longer be protected by the HIPAA Privacy Rule. I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

_____ _____
Signature of Client or Guardian Date