AUTHENTIC
THERAPY SERVICES LLC

Authorization for Release of Confidential Information

Client Full Name: _____ **Date of Birth:** _____

I, _____ authorize Authentic Therapy Services LLC ("ATS")

Authentic Therapy Services LLC
35 S Duke Street, York, PA 17401
Phone: (717) 819-9500 Fax: (717) 819-9794
info@authentictherapyservices.com

To:

- ☐ Release information to
- ☐ Obtain information from
- ☐ Exchange information with

_____ _____
Name of Individual or Organization Phone

_____ _____
Address Fax

_____
City State Zip

By providing my signature, I authorize the release of the following information:

___ Assessment
___ Psychosocial Evaluations
___ Psychiatric Evaluations
___ Current Treatment Updates
___ Medical History / Evaluations
___ Discharge Summary
___ Other: _____
___ Diagnosis
___ Psychological Evaluations
___ Treatment Plan or Summary
___ Medication Management
___ Educational Records
___ Continuing Care Plan

For the purposes of:

___ Coordination / Continuity of Care
___ Diagnostic Clarity
___ Other: _____
___ Treatment Planning
___ Referrals

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This release is valid for a period of one year, unless otherwise limited to the following dates: _____ through _____.

Client Rights:

- I understand that I have the right to revoke this release at any time by providing written notice to Jenn Sevier, LPC at Authentic Therapy Services, LLC, except to the extent that my provider has already taken action upon the authorization.
- I understand that Authentic Therapy Services will not condition my treatment on whether I give authorization for the requested disclosure, and that I have the right to refuse to sign this form.
- I understand that information disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by the HIPAA privacy regulations, unless a state law that is more strict than HIPAA provides additional privacy protections.

_____ _____

Client Signature Date

_____ _____

Client Name (Printed) Date

_____ _____

Signature of Guardian/Personal Representative Date

If signing as a personal representative, please describe your authority to act on behalf of this individual (i.e. power of attorney, guardian, healthcare surrogate, etc): _____

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