

Agape Empowerment Counseling Services, LLC

6919 E. 10th Street, Suite C-4
Indianapolis, IN 46219
(317) 543-9769

Authorization for Release of Confidential Information

This form, when completed and signed by you, authorizes me to release/receive protected information from your clinical record to/from the person or entity you designate.

I authorize my counselor, Arlinda D. Lindsay, her administrative and clinical staff to release/receive the following information pertaining to myself:

- Letter stating intake and session dates
- Intake Summary and Diagnosis
- Any information needed to obtain mental health insurance benefits
- Other (please be specific) _____

This information should only be released to/from (name and address of person or entity to which the information is to be released):

Name: _____
Address: _____

Phone: _____

I am requesting my counselor to release/receive this information for the following reasons:

- At my request
- To obtain mental health insurance benefits
- To coordinate treatment efforts
- Other (please be specific): _____

I have the right to revoke this authorization, in writing, at any time by sending such written notification to the above office address. However, such revocation will not be effective to the extent that this office has taken action in reliance on the authorization or if this authorization was obtained as a condition for obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my counselor generally may not condition counseling services upon my signing an authorization unless the counseling services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Signature*

Date

Print name: _____

**If a personal representative of the client signs this authorization, a description of such representative's authority to act for the patient must be noted.*