Horizons Counseling Services
5851 Pearl Road, Suite 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 organization designated below, the following information:

_____

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

_____

Name: _____ email: _____
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 (specify): _____

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. Any re-disclosure by a health care provider would also be guided by HIPAA privacy rules.

_____ _____
Signature of Client or Guardian Date