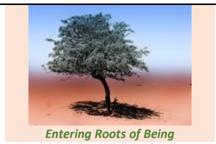

Counseling and Spirituality
George Campbell Hage, Ed. D., Ph. D., LCMHCS, 3151 Reynolda Road NW, Winston-Salem, NC 27106,
Tel: 336-406-1018, email: george@counselingandspirituality.org.in

HIPAA Compliant Release of Information (Report/Official Records)

Primary Client

I, ____, give permission to George C Hage, EdD, PhD, LCMHCS to use and disclose the following protected health information to:

Secondary, Tertiary and Quaternary Clients
____
____
____
[Name(s) of entity to receive information]

Information to be disclosed (check all that apply):
X Verbal Summary of Treatment Counseling
___ Copy of Psychological Report (Written)
___ Treatment Records
___ Diagnostic Records
X Other: Written Summary of Treatment Counseling______________________
____
____

This protected health information is being used or disclosed for the following purposes:
To effect confidential Treatment Counseling_
____
____

This authorization expires ____________________________________ (date or event)
Dated at the First full session.

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. You may inspect or copy the protected health information to be used or disclosed under this authorization. You may revoke this authorization in writing at any time by sending written notification to George C Hage, EdD., PhD. LCMHCS, 4061 Tangle Lane, Winston Salem NC 27106. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

____ ____________
Signature of Child or Legal Minor Date

____
Printed Name of Child or Legal Minor

____ ____________
Signature of Participant or Personal Representative Date
Primary Client

____
Printed Name of Participant or Personal Representative
Primary Client