Soulful Sage Counseling, LLC

Authorization to Release Information — Designated Individual

Soulfulsagecounseling.com | Soulfulsagecounseling@gmail.com

I authorize Soulful Sage Counseling, LLC to disclose and/or exchange the information described below with the individual named, for the purpose stated below.

Client Information

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

Individual Authorized to Receive / Exchange Information

Name of Individual _____ **Relationship to Client** _____

Address _____

Phone Number _____ **Email Address** _____

Organization / Practice (if applicable — e.g., another provider, school, attorney) _____

Purpose of Disclosure

Describe the reason for this release (e.g., care coordination with another provider, family communication, school accommodation, legal proceeding):

_____

_____

Information to Be Disclosed

Check all that apply:

☐ Confirmation of attendance / participation in treatment

☐ Diagnosis

☐ Treatment plan / progress summary

☐ Session notes / clinical records

☐ Ability to discuss treatment verbally (phone / in person)

☐ Other: _____

Note: This authorization does not, by default, permit release of psychotherapy process notes or substance use treatment records protected under 42 CFR Part 2. A separate, specific authorization is required for those records.

Method of Disclosure

☐ Fax ☐ Mail ☐ Secure Email / Client Portal ☐ Phone (verbal) ☐ In Person

Duration of Authorization

This authorization is valid from the date signed until the earlier of: (a) the date written below, (b) the end of the current treatment episode, or (c) one (1) year from the date of signature, unless revoked in writing sooner.

Expiration Date (optional — leave blank to default to 1 year or end of treatment)

Your Rights

You may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it. Information disclosed under this authorization may be subject to redisclosure by the recipient and, once released, may no longer be protected by HIPAA. Treatment may not be conditioned on signing this authorization, except as permitted by law.

Acknowledgment & Consent

By signing below, I authorize Soulful Sage Counseling, LLC to release the information indicated above to the individual named, for the stated purpose.

Client (or Legal Representative) — Signature *Date*

Clinician — Signature *Date*