PATHWAYS COUNSELING CENTER, LLC.

211 W. Hibiscus Blvd Melbourne, Florida 32901 Phone: 321-622-6710 Fax: 321-622-6715

HEALTH INFORMATION RELEASE FORM

I authorize the persons below to have access to any and all of my health information, including mental health, HIV, drug, and alcohol abuse records. Pathways Counseling Center, LLC. is permitted to share any medical information with them, including test results and information disclosed during office visits.

I hereby request and authorize:
Pathways Counseling Center, LLC ____ to release to ____to obtain from

Persons/Primary Care Physician/Psychiatrists or other medical provider authorized to receive my medical information (full name and phone number).

_____

_____

_____

_____

You may notify me, or the parties listed **above** with appointment reminders and other information regarding my health information.

Print Name_____

Signature_____ Date_____

Witness_____ Date_____

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further redisclosure is strictly prohibited unless the person provides specific written consent for the subsequent disclosure of this information. Florida Law requires that any person, agency, or entity receiving information shall maintain such information as confidential and exempt from the provisions of the public records law.

CONSENT TO TREAT

I hereby give consent to treatment to *Pathways Counseling Center, LLC* and_____.
(Therapist's name)

In a very small number of situations, counselors are legally required to disregard confidentiality. For example, if you reveal information that indicates a clear danger of injury to yourself or others (e.g., potential suicide or homicide) the counselor will need to contact appropriate authorities or family members. Also, all helping professionals are required by law to report any knowledge of the abuse or neglect of a child or an incompetent or disabled person. Your counselor will be happy to discuss any concerns you have about the protection of the information you provide.

READ & INITIAL BELOW:

_____**I have been informed that if I have advance directives that include psychiatric designations it is my responsibility to supply that to this office.**

_____**I am aware that if I miss a scheduled appointment or cancel less than 24 hours in advance, I will be charged a $40 missed appointment fee. I give permission to charge the credit card on file for the fee.**

_____**I am aware that the website has the HIPPA Privacy Practices and Pathways Counseling Centers, LLC Financial Policies for my viewing or hard copies are available to me upon request. In the event I participate in phone or internet sessions I understand that HIPPA compliance is not guaranteed**.

_____**I understand the limitations of confidentiality of Internet and mobile device-based communications.**

I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

_____
Print Name of Patient or Personal Representative

_____ _____
Signature of Patient or Personal Representative Date

Witness:_____ Date:_____