Personal Growth Therapy
EMDR FOCUSED TREATMENT

CONFIDENTIALITY RELEASE FORM

I, _____, authorize _____
(Patient Name) (Clinic, Counselor, or Doctor's Name)

to disclose to _____ the copies of any
(Name and Location of Person(s)/Organization to Receive Information)

and all records and information which you may have in your possession. This includes all the transmission of information and data via verbal and electronic contact.

These records and information include, but may not be limited to:

- ❒ Medical Records
- ❒ Medical opinions, diagnosis, progress notes, and recommendations
- ❒ Treatment plans and progress
- ❒ Description of treatment and prescriptions
- ❒ Charting Notes
- ❒ Other _____

I understand that the purpose of this disclosure is: _____

This authorization expires on: _____, or when

_____, is no longer providing me with services.

I understand that my records are protected under Federal regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

Print Client Name _____ Date_____

Signature of Client _____

Date of Birth _____

Print Therapist Name_____Date_____

Signature of Therapist_____

ATTENTION RECIPIENT – Notice Prohibiting Redisclosure

This information has been disclosed to you from the records protected by Federal confidentiality rules 42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug patient.