AUTHORIZATION TO RELEASE INFORMATION

I, _____, (hereinafter "Patient") hereby authorize _Debbie_____ _Glover_____, (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Patient, including but not limited to, therapist's diagnosis of Patient, to:

_____

_____

_____

I understand I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has already taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at 810 Travelers Blvd, Ste H1, Summerville SC 29485 to be effective.

This disclosure of information is required for the following purposes: _____

_____

The specific types of information to be disclosed includes: _____

_____

The limits to the information disclosed includes: _____

_____

The Provider shall not condition treatment upon Patient's signing this authorization and Patient has the right to refuse to sign this form. The Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable state law may protect such information.

This authorization shall remain valid for one year from date of signature.

Patient's signature:

_____

Date: _____