

**Authorization for Release of Confidential Information-**

Client Name	Client Name
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I authorize *Henry Therapy, LLC* and the persons or entities listed below, or their representatives, to mutually release and disclose my health information.

I have received and reviewed the *Notice of Privacy Practices*.

I understand that only Ryan G. Henry or other representatives from *Henry Therapy, LLC* may ask me to sign this authorization.

I understand that by signing this General Authorization I am authorizing *Henry Therapy, LLC* to disclose my health information to the persons and entities listed below and that any health information or other confidential information in the possession of the persons and entities listed below may be disclosed to *Henry Therapy, LLC*. My health information includes, without limitation, any records, reports, test results, opinions, assessments and any other information relating to medical, emotional, educational or psychological condition. Disclosure may also be made within *Henry Therapy, LLC* case consultation meetings to discuss treatment and review case progression.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to *Henry Therapy, LLC* where I am receiving counseling. I understand that my revocation of this *General Authorization* will not affect a disclosure that Ryan G. Henry or other representative from *Henry Therapy, LLC* has already made under this authorization.

I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by Henry Therapy's confidentiality rules.

I waive any right of privacy that I may have in connection with the disclosures hereby authorized.

For parents of minors receiving services: I authorize \_\_\_\_\_ to receive services provided by *Henry Therapy, LLC*. This release authorizes any necessary psychological and/or psychiatric evaluation and treatment. My signature below indicates that I agree and give consent to the above services. I also understand that parental participation in one or more of the following ways may be required: assessment, individual counseling, marital counseling, family counseling, parenting skills training or group counseling.

This authorization is only valid until \_\_\_\_\_ [fill in date], or until six months after my file is closed at *Henry Therapy, LLC*.

Henry Therapy, LLC	Address: 3848 Flatiron loop Wesley Chapel, FL 33544	Client's Initials
Name	Address	Client's Initials
Name	Address	Client's Initials
Name	Address	Client's Initials
Name	Address	Client's Initials

Signatures			
Client's signature	Date	Client's signature	Date
Name of parent or guardian (if client is under 18)	Date	Name of parent or guardian (if client is under 18)	Date
Witness	Date	Witness	Date