Thrive Counseling, LLC
982 Douglas Avenue Altamonte Springs, FL 32714
Office: (407) 476-9646

Consent for the Release of Confidential Information

I, _____, authorize A.J. Tarulli, MA, LMFT (MT 2731) to release and receive information about specific aspects (specified below) of my counseling, beginning on _____/_____/_____ (date) and ending with the completion of services. I understand that, if I so desire, I can terminate this consent at any time, and the termination date will be noted below.

The person to whom the information is to be released is: _____

Address: _____

Phone: _____ Fax Number: _____

Email: _____

The relationship of this person to me is: _____

The purpose of this release is *(check all that apply)*:

☐ Coordination of Services/Referral ☐ Legal Conditions
☐ Family Support/Involvement ☐ Consultation
☐ Other: _____

The information to be released is *(check all that apply)*:

☐ Assessment ☐ Attendance
☐ Progress Notes ☐ Other: _____

Method of Contact *(check all that apply)*:

☐ Telephone ☐ Email
☐ Facsimile ☐ Other: _____

I understand that this release gives my counselor permission to provide privileged information, usually kept confidential, to the person above. This form releases my counselor from liability for the release of the above information.

To the party receiving the information:
This information has been disclosed to you from records whose confidentiality is protected under Federal Law. Federal Regulations (HIPAA, 42 CFR Part 2) prohibit you from making any further disclosure without the written consent of the person to whom it pertains. A general authorization for the release of medical or other information is not sufficient for this purpose.

Client Signature: _____ Date: _____

Parent/Guardian Signature (if minor client) and Date:_____

Counselor Signature and Date: _____ Date: _____