THREADS THERAPEUTIC SERVICES

Release of Information

I hereby authorize ___Kateece Freeman LPC, NCC___ (Therapist's name) of Threads Therapeutic Services, LLC

to: ◯ release ◯ receive ◯ exchange

information concerning _____ _____
(Name of Patient) (Date of Birth)

◯ to ◯ from

◯ with _____.
Identified Party

I understand that such disclosure will be made for the following purposes:

◯ Treatment Progress
◯ Social History
◯ Academic Placement
◯ Psychiatric Evaluation
◯ Medical Treatment
◯ Diagnosis _____
◯ Psychological Evaluation
◯ Treatment Summary
◯ Other _____

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance herein, and, if not earlier revoked, it shall terminate on __One year from date of signature__ without revocation.

I understand that disclosures may not be subject to confidentiality if the therapist becomes aware of any suicidal or homicidal thoughts or plans, or in the event that the therapist becomes aware of any form of abuse or neglect.

I understand that the therapist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

I have read, or had read to me, the above, and understand the contents.

_____ I authorize this information to be forwarded via facsimile, email or regular U.S. Mail to the party indicated above and understand the limits of initial confidentiality which doing so creates.

_____ _____
Signature of Patient, Parent, or Legal Guardian Date

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Contact: (470) 519-2542