Kim Asher, LPC, CCH
6100 Lake Forrest Drive,
suite 450
Atlanta, GA 30342
kimasher@comcast.net
404-610-8625

Name:

DOB:

I authorize

Therapist Name: Kim Asher LPC

Therapist Address: 6100 Lake Forrest Drive ste 450 Atlanta, GA 30328

Consent Release of Information

To disclose and or obtain treatment information to and/or from the following:

Name:

Address:

Phone:

Email:

Please signature below if you agree to release ALL of your Protected Health Information.

If you are limiting the information that is released, please list ONLY the information you agree to be released:_____

By signing below I acknowledge that the above information about me may be released, discussed, or disclosed. I understand that my records are protected under Federal Regulations governing Confidentiality of Protected Health Information (PHI) under HIPAA and Confidentiality , and cannot be disclosed without my consent unless otherwise provided for the regulations. I also understand that I may revoke

this authorization at any time and must do so in writing and present this written revocation to my therapist. I understand that once information is disclosed as per my authorization, the recipient, in accordance with eh applicable laws and regulations, may re-disclose the information and it might not be protected by federal or state privacy regulations.

Signature of client and/or parental or guardian of client under the age of 18.

_____ Date_____