“Peace, in simple terms.”

Counseling Services, PLLC

Release of Protected Information

Client:	
Counselor: **Gregory Koprowski, LPCA** Address: 169 E. Reynolds Rd. Ste 205D Lexington, KY 40517 Phone: (859) 448-7379	Recipient: Address: Phone: Fax:

This document, when completed and signed, authorizes the Counselor to release protected information about the Client to the Recipient. This information may be released in-person, over the phone, through the mail, or by fax, unless otherwise noted.

The information being released will include:

_____

_____

The purpose of releasing this information:

_____

_____

This authorization will remain in effect until (event or date):

_____

(Unless otherwise noted this authorization expires 90 days after the date of Client signature.)

The Client has the right to revoke this authorization at any time, effective when the counselor has received the request that this release be revoked and acknowledged receipt. Revoking this authorization has no effect on information already disclosed in accordance with this authorization.

The Recipient is bound by their own confidentiality agreements with the Client. The Counselor is not responsible for the confidentiality of information once it is given to the Recipient. The Client understands that entities not covered by HIPAA regulations may disclose the Client’s information without consent.

Client Signature:_____ Date:_____