Anjana Freeman, MS LPC

Mental Health Consultant and Therapist
Rape Response, Inc

I, (full name) ____ (Date of Birth) ______/______/______/

give permission to Anjana Freeman, LPC to **obtain information related to my treatment** from:

Name and organization:

____

Phone number

____

Fax number

____

I, (full name) ____ (Date of Birth) ______/______/______/

give permission to Anjana Freeman, LPC to **share information related to my treatment** from:

Name and organization:

____

Phone number

____

Fax number

____

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1. Information Related to Treatment May Include: **(check all that apply)**

- ☐ Assessment/Diagnosis/Family History
- ☐ Psychological Testing/Consultation
- ☐ Treatment History
- ☐ Treatment Summary and Recommendations
- ☐ Medical Information/Prescribed Medications
- ☐ Substance History and/or Treatment
- ☐ Other (please specify): ____

2. I authorize the release of my complete health record with the exception of the following information:

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): ____

ANJANA FREEMAN M.S. LPC
ANJANAFREEMAN@RAPERESPONSE.COM
678-943-5956

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Rape Response, Inc

3. **This authorization for release of information covers the period of healthcare from:**
   a. _______________ to _______________.

      OR
   b. all past, present, and future periods.

4. **This authorization shall be in force and effect until** ____________________ (date or event), at which time this authorization expires.

5. **I understand that I have the right to revoke this authorization**, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
6. **I understand that my treatment, enrollment, or eligibility for benefits will not be conditioned** on whether I sign this authorization.

____

Signature of patient or legal representative

____

Printed name of patient or legal representative and his or her relationship to patient

____

Date