

Debbie Malloy, LPC, LLC Informed Consent and Authorization CONFIDENTIAL

Expiration: I understand and agree that this authorization will be valid and in effect until: \_\_\_\_\_\_\_\_. I understand that after that date, this information cannot be obtained by/released to the person or organization unless I sign a new authorization form such as this one.

Revocation: I understand I can revoke or cancel this authorization at any time by sending a letter to Debbie Malloy LPC, LLC.

I understand that I do not have to sign this authorization and that I may inspect and have a copy of health information described in this authorization.

I understand that if the person/entity who receives this information described above is not a health care provider, or health plan covered by federal regulations, the information described above may be re-disclosed and no longer protected by those regulations. I affirm that this form has been explained to me, and I understand the terms and conditions.

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

(Initial)\_\_\_\_\_\_\_\_\_ I authorize this information to be faxed or otherwise transmitted to the party indicated above, and I understand the limits of confidentiality which doing so creates.

(Initial)\_\_\_\_\_\_\_\_\_ I have received and read the above information. However, at this time, I do not have anyone to whom I wish to release information.

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Signature: Client, Parent, or Legal Guardian***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Therapist***

Debbie Malloy, LPC, LLC is committed to providing quality mental health services. I understand that my counselor will inform a third party without my consent if I make credible or direct threat of harming myself or others. I further understand that my counselor is legally obligated to inform any appropriate authority without my consent if information I provide leads my counselor to believe that there is abuse or neglect of children, the elderly, disabled or mentally or legally incompetent individuals.

I understand that text, cell phone calls and some emails are not secure communications, and might be intercepted by unauthorized parties. I understand that I am responsible for payment for all face to fact, tele-mental health and phone sessions at the end of each session and that I will be charged full rate for any missed session without 24 hours notice, unless circumstances are unavoidable.

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***Signature of client/parent/legal guardian Date***