THE FIRST HOPE CENTER
THINK. LEARN. GROW

Release of Information From

Address Office:

CP-109, Fairway Commercial, Raya Golf Resort,
DHA Phase-VI, Lahore, Pakistan

+92 322 5585504 thefirsthopecenter@gmail.com

Date : / /

I have the authority to consent for this minor child and give my permission to The First Hope Center, to release or request from a third party information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative.

This information will be released/requested upon request to the following:

Full Name :

Email Address :

Phone Number :

The type of information to be disclosed/requested is as follows:
To Be Released * *from The First Hope Center,* To Be Requested * *from third parties*

____Treatment Plans
____Process Notes
____Health/Medical Records (if applicable)
____Letter(s) of Progress
____Bio Psychosocial Evaluation/Assessment (if applicable)
____Psychological/Psychiatric Evaluations/Assessments
____Court Documents
____Verbal Communication
____Other (Specify): _____
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- **I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to The First Hope Center.**
- **I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and The First Hope Center will not base my treatment or payment on whether or not I provide authorization for the requested use or disclosure. I understand that I may inspect or copy the information to be disclosed.**
- **I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws, and The First Hope Center will not be held liable for information disclosed to another party per the client's request.**
- **I understand that The First Hope Center will release only the minimum amount of information necessary to fulfill a request.**
- **This authorization shall expire when the client is discharged from the current episode of care (treatment has been completed, the client rejects/declines/drops out of treatment, is referred elsewhere, moves, or in the case of the client's death). This agreement is subject to revocation in writing at any time.**
- **In the case of notes documenting or analyzing the contents of conversation during a private counseling session ("process notes"), we reserve the right to provide a report of examination or treatment in lieu of copies of the actual records, unless requested by/for a treating psychotherapist.**

Customer Signature

Clinical Name/Credentials