**HOPE COUNSELING CENTERS**
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# RELEASE OF INFORMATION FORM

I _____ hereby authorize Hope Counseling Centers to send/ obtain/ share mental health records to / from the following:

_____

_____

_____

Client Signature: _____ Date: _____

Counselor: _____ Date: _____

Please list any additional information if need:

_____

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PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further re-disclosure is strictly prohibited unless the client provides specific written consent for the subsequent disclosure of this information. By authority of Section 394.459 (Florida Statues) HRS-MH FORM 3044, Nov. 81 (Obsoletes previous editions and DMH-BA44).