CLIENT AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

I, _____, give my authorization and consent for Joyce Starks to discuss my current and/or past therapy and therapeutic needs, and/or my personal history with the person(s) named below:

Name Phone

I understand that my personal therapy information is protected under the Health Insurance Portability and Accountability Act of 1996('HIPAA'), 45 CFR, Parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time and that that any notice to revoke consent must be in writing.

Signature:_____

Date: _____

Witness: _____

Date: _____