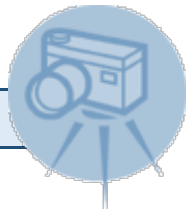
Release Form for Electronic Health Record



I, the undersigned, do hereby consent and agree that Eclectic Therapeutic Connections, PLLC, its employees, or agents have the right to take a photograph of me beginning on _____, and ending on _____ and to use in my electronic health record exclusively for the purpose of identification of my record.

I do hereby release to Eclectic Therapeutic Connections, PLLC, its agents, and employees all rights to post in my file but they may not publicly or privately market and sell copies. My rights are protected. My right to confidentiality has been explained to me, and I understand the information to be released, the purpose of the release, and the statutes and regulations **federal privacy law (45 C.F.R. 164.512 of HIPAA)** protecting my confidentiality. I understand that I may revoke this consent at any time, either verbally or in writing, except where releases of information based upon this consent have already occurred. Other laws, however, may prohibit re-disclosure. When we disclose mental health and developmental disabilities information protected by **state law (G.S. 122C)** or substance treatment information protected by **federal law (42 C.F.R. Part 2)**, we must inform the recipient of the information that re-disclosure is prohibited except as permitted or required by the laws.

This consent will automatically expire on: _____ (date, not to exceed one year) or, 90 days after discharge from services, whichever comes first. I may request a copy of this signed authorization.

_____ _____

Client Signature Date

_____ _____

Guardian (Relationship to Client) Date

_____ _____

Therapist Date

*Client must sign whether a child or adult, information protected by Federal Regulations 42CFR part 2