Family Outreach & Counseling Center Inc, (FOCC)

200 West Sugar Creek Rd.
Charlotte, NC 28213
Phone/Fax:704-509-9917

CONSENT/AUTHORIZATION FOR RELEASE OBTAIN/EXCHANGE OF INFORMATION

Client Name: _____

I hereby authorize the following party to release to and/or exchange information with Family Outreach & Counseling Center:

Name: _____

Address:

_____

_____

Phone: _____ **Fax:** _____

The purpose of this release is for:

_____ Continuity of care
_____ Coordination of care with another treating healthcare provider
_____ Insurance plan or third party-payer review of records for quality and level of care and/or justification of charges, and as needed to authorize more sessions or to process claims, or to fulfill administrative review by plan
_____ Other: _____

The information released will be limited to:

_____ Attendance
_____ Assessment/ Summary
_____ Diagnosis
_____ Discharge Summary
_____ Summary of pertinent psychiatric and psychosocial history
_____ Treatment summary
_____ Complete mental health assessment and treatment records
_____ Any information deemed necessary to coordinate care
_____ Other_____

The requesting party certifies that information will not be used for any purpose other than its intended use and will not be re-released to another party. The client understands that s/he has a right to a copy of this form. This consent is subject to revocation at any time except to the extent that action has been already taken in reliance thereon. If not revoked earlier, this consent expires three years from the date signed. I understand that after this information is disclosed, federal law might not protect it, and the recipient might re-disclose it. I agree to release FOCC from liability that may result from furnishing this information as authorized in this disclosure.

_____ _____

Signature Date

_____ _____

Second Party Signature Date