AR NextStep
Counseling Services

AUTHORIZATION FOR RELEASE OF INFORMAITON

ALL ELEMENTS ARE REQUIRED PRIOR TO INFORMATION BEING RELEASED

1:	Client Name:		DOB:		SSN:

2: I consent for AR Nextstep Counseling Services located at 800 S. Church Street, Suite 103, Jonesboro, AR 72401 to:

	Release my records from:	**Allow verbal communication with:**

3:		Located at				
	Name of Entity/Person		Full Address	City	State	Zip

4: SPECIFIC INFORMATION REQUESTED/TO BE RELEASED (please check all that apply)

	School:		DCFS:		Other:
	Grade Reports		DCFS Case Plan		Intake/Psychosocial History
	Conduct Reports		Court Orders		Psychiatric Eval/MD Notes
	Attendance Records		Alcohol/Drug Tx		Therapy Notes
	IEP (if applicable)		Medical (physical)		Psychological Testing
	Psychoeducational Testing		Other:		Treatment Plan/Updates
					Discharge Summary

Other information requested to be released:

List dates of service:

Authorization for the above listed person to accompany my child to their appointments.

5: The purpose of this release of information is:

	Continuity of care		Legal Reasons		School/Educational
	Disability		Insurance		Other:

6: I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

7: I understand that AR Nextstep Counseling Services may charge for the costs of copying the information to be released and I understand that AR Nextstep Counseling Services has up to 30 days to retrieve and copy the medical record.

8: I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed under this authorization.

9: I understand that I may revoke this authorization in writing at any time by delivering a copy of my revocation AR Nextstep Counseling Services except to the extent that action has been taken in reliance on this authorization. This authorization expires (mm/dd/year).

Client's Signature Date

Parent/Guardian Signature Date

Witness Signature Date

Witness Signature Date

2315 E. Matthews Ave.
Jonesboro, AR 72401
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