Release of Information

Authorization of Disclosure of Records

I hereby authorize Jeremiah Guidos, MA, LCPC to disclose/receive the following information to/from the records of:

Name: _____ Date of birth: _____

To/From: _____

Phone: _____ Fax: _____

Address: _____

I specifically authorize the release of the following:

Please check information to be disclosed

- ☐ Assessment and Diagnosis
- ☐ Psychiatric/Mental Health Treatment Records
- ☐ Progress in Treatment
- ☐ Drug and Alcohol Treatment Records
- ☐ Other - Specify _____
- ☐ Evaluations
- ☐ Treatment Plans
- ☐ School Records
- ☐ Entire Health Record

The above information will be used for the following purposes: diagnosis and treatment, coordination mental health and medical care, administration of health care service plans, coordination of family treatment and/or other (specify): _____

I hereby authorize the use or disclosure of my protected health information as specified above. This authorization permits disclosure of information about mental illness or substance abuse conditions, as well as other health conditions and information. I understand that this authorization is voluntary and that I may refuse to sign it. I understand that I may revoke this authorization at any time by giving written notification to my provider. A revocation will not affect any action taken in reliance on the authorization prior to the revocation. Other limitations on my right to revoke this authorization may be found in my provider's Notice of Privacy Practices. I understand that, if the recipient is not a health care provider or a health plan, the information disclosed under this authorization may no longer be protected by federal privacy regulations and may be re-disclosed by the recipient. I understand that I should receive a copy of this authorization, even if I do not ask for it. This consent is effective for one (1) year from the date it is signed unless otherwise specified as follows:_____

Signature of Client: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____