CONNECTING STEPS COUNSELING

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

______________________________ ______________________________
Client Name Date of Birth

By signing below, I authorize the information specified below regarding the above person be disclosed between, Connecting Steps Counseling and:

1. ______________________________ ______________________________
Person(s) or Organization Relationship to Client

______________________________ ______________________________
Phone Email

2. ______________________________ ______________________________
Person(s) or Organization Relationship to Client

______________________________ ______________________________
Phone Email

3. ______________________________ ______________________________
Person(s) or Organization Relationship to Client

______________________________ ______________________________
Phone Email

Information to be disclosed: **(Put your initial on line of each category unless you chose all information)**

_____ All Information
_____ Assessment/Recommendations
_____ Attendance in Service
_______ Progress Notes
_______ Treatment Goals
_______ Discharge Summary

Release requiring specific consent:

_______ Drug/Alcohol Abuse
_______ Sexually Transmitted Diseases

1. I understand that the intent for release of this information is to coordinate care and maintain continuity of care with the practitioner, organization, or persons identified above.
2. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected under federal law.
3. I understand that my refusal to sign this authorization will not jeopardize my right to present or future treatment for psychiatric disabilities, except where disclosure of the information is necessary for the treatment.

____
Signature of Participant/Client Date

____
Signature of Parent/Legal Guardian Date