Release of Information

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Client's Full Name: _____ **Date of Birth** _____

Directions: Enter your name under the first question "I, __". Please indicate the information and parties you consent information to be obtained and/or released between.

* Indicates a required field.

I, _____ authorize, The Counselor Care, LLC to use or disclose information regarding: ☐ Self ☐ Child If other relationship to client, specify _____

I understand that information from mental health records, may include information about psychological diagnosis, treatment, and/or substance use.

*I authorize Counselor Care, LLC to: ☐ Release/Disclose Information ☐ Obtain Information

Between (Name of person/agency/company): _____

Phone: _____ **Contact:** _____ **Email:** _____

Address: _____

Information to be exchanged includes:

☐ Full Disclosure of Information and Clinical Records

*I understand that the information may contain psychiatric/psychological, alcohol/substance abuse, and/or other health information and I expressly consent to the release of the information.

I authorize ☐ MENTAL HEALTH and/or ☐ SUBSTANCE USE information to be obtained if contained in selection(s) below:

- ☐ Treatment Summary/Status Update (Verbal)
- ☐ Intake Assessments
- ☐ Substance Use Assessments
- ☐ Diagnostic Summaries
- ☐ Treatment Plans and Reviews
- ☐ Discharge Summaries Service
- ☐ Psychiatric/Psychological Evaluations
- ☐ Clinical Progress Notes
- ☐ Medications/Prescriptions
- ☐ Labs/Test Results
- ☐ Attendance/Treatment Verification
- ☐ Financials
- ☐ IEP (Individualized Education Program/Plan) Other:

Purpose of Disclosure:

- ☐ Planning appropriate treatment or program
- ☐ Continuing appropriate treatment or program
- ☐ Determining eligibility for benefits or program
- ☐ Court
- ☐ Case review
- ☐ Family/Support System update
- ☐ Employment
- ☐ School/Education

I understand that my substance use treatment records are protected under federal regulations governing the confidentiality of substance use patient records 42 CFR Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for by the regulations. Persons receiving confidential information may not further disclose such information if the information concerns substance use or treatment. However, I also understand that persons receiving other types of confidential information may have the ability to disclose the information as allowed by relevant state law and federal regulations. In that case, and to the extent that such re-disclosure may take place, this information will no longer be confidential.

I understand that if I authorize disclosure using a general designation, that I will be provided a list of entities to which my information has been disclosed.

I understand that I will not be denied services if I refuse to sign an authorization to release information and that I may revoke this authorization verbally or in writing except to the extent that action has already been taken in reliance on it. THIS AUTHORIZATION EXPIRES 1 Year from signature date.

By signing, I consent to the release of information.

*If signing below on behalf of client, please check the basis for your authority. Documentation proving authority may be required.

☐ Parent of Minor ☐ Guardian ☐ Power of Attorney ☐ Other Authorized Representative

_____ _____

Signature **Date**