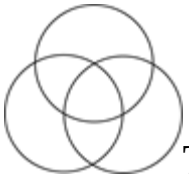


Trilogy Counseling Services

Authorization for Release of Information

Client Name:_____

Date of Birth:_____

Social Security Number:_____

I authorize Trilogy Counseling Services, LLC to: ___ release to ____ obtain from (check applicable)

Specific Information to be Released by Trilogy Counseling Services:

Psychological History: ___ Psychological Evaluation: ___

Staffing/Progress Notes: ___ Discharge Summary: ___

General/Verbal Information: ___ Urine Analyses Information: ___

Specific Information to be Released to Trilogy Counseling Services:

Psychological History: ___ Psychological Evaluation: ___

Staffing/Progress Notes: ___ Discharge Summary: ___

General/Verbal Information: ___ Urine Analyses Information: ___

Individual and/or Agency Information:

Contact: _____

Address: _____

Phone/Fax: _____

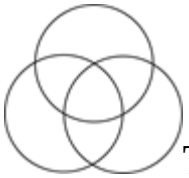
Purpose for Disclosure:

Emergency Contact: ___

To Assist in Therapeutic Process: ___

To Facilitate Family Involvement in Treatment: ___

Other Reasons *(please specify)*: _____



Trilogy Counseling Services

I hereby hold Trilogy Counseling Services, LLC and its agents and officers harmless from any acts taken consistent within this organization. I am also aware that I have the right of access to any information received from or released to Trilogy Counseling Services. LLC. I understand that reports released may include psychological, alcohol/drug screen abuse or dependence records. This consent may be revoked by a client at any time, except to the extent that cation has been taken in reliance thereon. I also understand that this consent, unless revoked earlier, shall be valid for one year. A copy of any release will be considered as valid as the original. This release is executed in conformity with 42CFR 2.31(b) and Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that I am under no obligation to sign this form and that the person/agent listed above, who I am authorizing to use and/or disclose my information, may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. I understand written notification is necessary to cancel this authorization.

_____

Signature of Client Date:

_____

Signature of Parent/Guardian Date:

_____

Signature of Witness Date:

_____

Signature of Revocation Date:

1245 Cheyenne Avenue, Suite 104 Grafton, WI 53024 P: 1.262.618.2832 / F: 1.262.421.8492