300 W. Washington Ave, Suite 210B

Jackson, MI 49201

Phone: 517-227-6038

E-mail: irwincounseling@icloud.com

**Irwin Counseling Service**

**Authorization for Release of Confidential Information**

***(All information is held strictly confidential)***

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize Irwin Counseling Service to Request/Disclose information in my clinical record to/from:

Name of Organization/Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_\_\_

**Specific information to be Requested/Disclosed (please initial all that apply):**

\_\_\_\_ Identifying Information \_\_\_\_ Diagnosis

\_\_\_\_ School Reports \_\_\_\_ Psychological Testing Information

\_\_\_\_ Communication with school personnel \_\_\_\_ Psychosocial History/Evaluation

\_\_\_\_ Treatment Plan \_\_\_\_ Discharge Summary

**Purpose or Need for Request/Disclosure (please initial all that apply):**

\_\_\_\_ Coordination of Care \_\_\_\_ Medication Review

\_\_\_\_ Evaluation/Assessment \_\_\_\_ Continuation of Services

\_\_\_\_ Aftercare Planning \_\_\_\_ Billing/Payment

This authorization, except for action already taken, may be revoked at any time by verbal or written notice to Irwin Counseling Service without expressed revocation this authorization expires after one year, or sooner for any one or more of the following reasons.

With the following restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For the period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This information disclosed to you from records whose confidentiality is protected by State and Federal Laws, which prohibit you from making any further disclosure of this information without specific consent of the client to whom it pertains or as otherwise permitted by such regulations. A general authorization for the request/disclosure of medical or other information is NOT sufficient for this purpose.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date Parent/Guardian Signature Date