Authorization to Release/Receive Information

Consumer: _____

Social Security Number: _____ DOB: _____

This authorizes Expansion Counseling Services, LLC to release/receive in writing or through telephone contact, general medical, psychological/psychiatric information including alcohol/drug abuse or addiction from my record in accordance with Georgia's Statues and the State of Georgia and Federal Administration Rules and Regulations to/from:

Name :_____

Address/Phone/Fax#: _____

Information to be released:

- Medical Histories and Physicals
- Progress Notes
- School Records
- Reports from Psychological Testing
- Results from Drug Screens
- Treatment Plan
- Assessment Report
- Close Summary
- Other

Purpose of Release;

- Continued Treatment
- Case Planning
- Other

Expires in one (1) year from date of signature or expires on _____ (date specified)

All information I hereby authorize to be obtained from or released to Expansion Counseling Services, LLC will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect unless I specify an expiration date. If this release is for court order psychological evaluation, it is understood that the report will be used as evidence in court. The psychological evaluation report will be released to the referring agency/attorney and you may request information from that agency of attorney. It is understood that this consent is subject to revocation at any time by the undersigned except to the extent that action has already been taken in compliance with this consent. Notice of Prohibition on Redisclosure: This information had been disclosed to you from records protected by Federal Rules governing confidentiality rules (42 CFR part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other investigation is not sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I hereby release Expansion Counseling Services, LLC from all legal responsibility that may arise from the release of the above requested information. This authorization is fully understood and it is made voluntarily and with informed consent on my part.

Signature (client/guardian): _____ Date:_____