**Release of Information**

Client: DOB:

I authorize: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ of Thriving Families Counseling Services to exchange information with the following person(s) or agency:

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

Information to be Released:

\_\_\_\_ Attendance

\_\_\_\_ Treatment plan, progress, and discharge reports

\_\_\_\_ Evaluation results & recommendations

\_\_\_\_ Psychological & psychiatric testing and evaluation results

\_\_\_\_ Information regarding social history

\_\_\_\_ Information regarding medical history

\_\_\_\_ Information regarding substance abuse (alcohol and drug abuse)

\_\_\_\_ HIV/AIDS related testing and information

\_\_\_\_ Others

(specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Purpose of Release:

\_\_\_\_ Legal investigation/ Court proceedings

\_\_\_\_ Treatment collaboration

\_\_\_\_ Determine eligibility for benefits

\_\_\_\_ Emergency contact

\_\_\_\_ Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Formats information can be shared in:

\_\_\_\_ verbal direct

\_\_\_\_ email

\_\_\_\_ written

\_\_\_\_ telephone/text messaging

\_\_\_\_ fax

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand what I have read and what was explained to me and agree to the terms and conditions stated above. Additionally, I understand either party may terminate this agreement at anytime by providing a letter or other written documentation regarding the request for termination. A photocopy or exact reproduction of this document shall have the same force and effect as this original. I understand that I have the right to refuse to sign this authorization.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian/Rep: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are the legal guardian or representative approximated by the court for the client, please attach a copy of this authorization to receive this protected health information.

TFSC Staff/ Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_