Little Birdie
PROFESSIONAL COUNSELING, PLLC

Release of Information

Little Birdie Professional Counseling, PLLC

112 N. 34th St. Rogers, AR 72756

Information to be released to/from:

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

I (we), the undersigned, do hereby authorize the above named persons, educational institutions, firms, physicians, clinics, hospitals, companies or agencies to use and/or disclose the following confidential information in written, verbal or electronic form. The above information is obtained, released, used or for the following purpose(s) only. Any other is forbidden

Specific Description of Information to be disclosed (please check either Y for Yes and N for No for each category.)

___Y ___N Discharge of Treatment Summary. **___Y ___N** Drug/Alcohol Screen Results

___Y ___N Dates of Treatment **___Y ___N** Progress Notes

Other (Specifically identify)

_____

The above information is obtained, released, used or for the following purpose(s) only. Any other is forbidden.

___ Insurance. ___ Continued Treatment. ___ Legal. ___ Upon Request of client or clients representative

I understand that my records are protected by state and federal law, and cannot be disclosed or re-disclosed without my written consent unless otherwise provided by law. I also understand that if I revoke the authorization, I must do so in writing on the back portion of this form. I understand that the revocation will not apply to my insurance company when the law provides the right to contest a claim under my policy.

I want the agency/person listed above to accept a copy of this form as a valid consent to share the information referenced above on an as needed basis to assist with service coordination and treatment planning. I understand the authorization of the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment/service. I understand that I may inspect or obtain a copy of the information to be used or disclosed as provided in CFR 164.524 I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my information, I can contact this provider. If I do not sign this form, information will not be shared. I hereby release any person, educational institution, firm, physician, clinic, hospital or agency, from liability for information furnished pursuant to this authorization

My signature below indicates that I have read and understand this document. The information to be released and/or received has been discussed with me.

Print Clients Name: _____ Phone: _____

Complete Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: _____

Witness Signature: _____ Date: _____