Release of Information

Client Name:	DOB:
Address:	
Phone Number:	

I hereby authorize:

Inner Resilience Counseling and Consulting, PLLC
2550 W. Union Hills Dr Suite 350
Phoenix, AZ 85027
And

Name:	
Address:	
Phone:	Fax:
Relationship to Client :	

SPECIFIC INFORMATION TO BE DISCLOSED

☐ASSESSMENT/DIAGNOSIS ☐COMMUNICATION EXCHANGE ☐PSYCHOSOCIAL/COUNSELING ☐TREATMENT PLAN/CONTRACT ☐ADMISSION/DISCHARGE DATA SET ☐SCHOOL/WORK RECORDS	☐PROGRESS REPORTS ☐DISCHARGE SUMMARY ☐DR. DISCHARGE SUMMARY ☐VERBAL COMMUNICATION ☐_____________________________ ☐_____________________________	☐REAUTHORIZATION FORMS ☐OTHER PERTINENT INFORMATION (Specify): ____ ____ Dates of Service:_____________________________

PURPOSE AND NEED FOR SUCH DISCLOSURE

☐CONTINUATION OF CARE ☐SCHOOL/WORK	☐ FAMILY NOTIFICATION ☐ REFERRAL FOLLOW-UP	☐OTHER (Specify)_________________________

I understand that my medical record may contain reports, test results and notes that only a care provider can interpret. I understand and have been advised that I should contact my care provider regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record. I will not hold Inner Resilience Counseling and Consulting, PLLC, or counselors liable for any misinterpretation of the information in my medical record as a result of not having consulted my care provider for the correct interpretation. I understand that generally my treatment may not be conditioned on whether or not I sign an authorization form, but that in certain limited circumstances I may be denied treatment if I do not sign an authorization form. This authorization is subject to a written revocation at any time except in those circumstances in which the counseling center has taken certain actions in reliance on such authorization. However, this authorization shall be valid no longer than is reasonably necessary to accomplish the purpose of the actions for which it was given. This authorization will automatically expire 12 months from the end of involvement in our programs or as specified in the revocation below.

____________________________________ ______________ ____________________________________ ______________
Client Signature (Guardian) Date Witness Date

☐**DRIVERS LICENSE/IDENTIFICATION VERIFIED**

REVOCATION (optional) – This authorization is revoked for the following specified dates, events, or conditions.

Date: ____________________Event: __________________________ Condition: ________________________________