

**Victorious Counseling Services**

99 Derby Street, Suite 200

Hingham, MA 02043

(P) 617-379-1464

Authorization for Release of Information

Client Name:

Date of Birth:

I do hereby Authorize: \_

**(Name** of current treatment program/provider)

To disclose to/from:

(Name of person/organization receiving Information)

(Street Address, City, State, Zip Code)

(Telephone Number)

The following Protected Health Information:

(Fax Number)

Dates of Treatment: \_

Discharge summary/ After care Plan Psychosocial Assessment

Psychological/Psychiatric Evaluation \_\_

Psychotherapy Notes \_\_

Back to Work Letter \_\_ Pogress in Treatment

Verification of Treatment Attendance Medication Regimen/Treatment

Other (specify): \_

For the Purpose of:

Coordination of Services

\_\_\_ Consultation

Other (specify\_): \_

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\_\_\_\_ By initialing I fully acknowledge that the Information released may contain records related to alcohol and/or substance abuse treatment protected under federal law 42 CFR Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

By signing this release form I understand that federal law prohibits the person or organization to whom disclosure is made from sharing any of this Information with any other entity unless permission Is granted expressly In writing by myself In accordance with 42 CFR Part 2.

I am aware that I may withdraw my consent at any time except to the extent that action has been taken in reliance on this statement of Informed consent. I also understand that even If I do not withdraw consent, this release of information will automatically expire on: or one year from the date of this signing.

(Signature of Client, Parent, Guardian or Legal Representative)