Client Name_____ DOB_____

Serenity and Sage Counseling, LLC Release/Obtain Client Information

Serenity and Sage Counseling, LLC has an obligation to keep my personal information, identifying information, and my records confidential. I also understand that I can choose to allow Serenity and Sage Counseling, LLC to release or obtain some of my personal information to certain individuals or agencies.

I, _____, authorize _____ or designee of Serenity and Sage Counseling, LLC to:

Release to: Obtain From:	Name of Individual/Institution: Address: Telephone Number: Fax Number: Email Address:

The information may be shared: ☐ In Person ☐ by phone ☐ by fax
☐ by mail ☐ by email

☐ *I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by other people.*

What information about me will be shared:	☐ All ☐ Diagnosis ☐ Treatment Plan ☐ Discharge Summary ☐ Other: _____
Why I want my information shared: (purpose)	☐ Continuity of Care ☐ Diagnosis ☐ Records coordination ☐ Reciprocal Communication ☐ Termination/Discharge ☐ Legal ☐ Personal Request ☐ Other:_____

I understand:

- That I do not have to sign a release form. I do not have to allow Serenity and Sage Counseling, LLC to share my information. Signing a release form is completely voluntary. This release is limited to what I write above. If I would like Serenity and Sage Counseling, LLC to release information about me in the future, I will need to sign another written, time-limited release.
- That releasing information about me could give another agency or person information about my location and would confirm that I have been receiving services from Serenity and Sage Counseling, LLC.
- That Serenity and Sage Counseling, LLC and I may not be able to control what happens to my information once it has been released to the above person or agency, and that the agency or person receiving my information may be required by law or practice to share it with others.

This release date expires on _____**(DATE)**

I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing.

Signed: _____
Date:_____ Witness:_____

To Recipient of this submission:

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR Pt. 2) prohibits your from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute the client.

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