

**Kimberly Ledwa, LCPC, ACADC**  
2971 E. Copper Point Dr. Suite 100  
Meridian, ID 83642  
208-376-5683 ext. 302

### **Client intake information (Child/teen version)**

Please fill out as completely as possible about your child. Include your child in providing answers as much as you feel is appropriate.  
This information is part of your child's confidential file.

#### **Identification**

Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
Home address \_\_\_\_\_ Apt \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Primary phone \_\_\_\_\_ Type: **cell** **home** **work**  
Email \_\_\_\_\_ Any contact restrictions? \_\_\_\_\_  
Preferred method of reminder for sessions (circle one): **email** **text** **both**  
Gender \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Religious Preference \_\_\_\_\_  
Other means you identify yourself that you consider important \_\_\_\_\_  
Family military experience \_\_\_\_\_

#### **Emergency Contact**

Name \_\_\_\_\_ phone # \_\_\_\_\_ relationship \_\_\_\_\_

#### **Referral**

How did you learn about counseling with me? \_\_\_\_\_

#### **Chief concern**

Please describe the main difficulty that has brought you to see me. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### **School**

Name of school \_\_\_\_\_ Current grade \_\_\_\_\_ Teacher/advisor \_\_\_\_\_  
Achievements/challenges \_\_\_\_\_  
\_\_\_\_\_  
Favorite subject(s) \_\_\_\_\_  
Least favorite subjects(s) \_\_\_\_\_  
Academic concerns \_\_\_\_\_  
Behavioral concerns \_\_\_\_\_  
*Any developmental or milestone challenges, past or current?* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### **Family of origin history**

*List who is in your home & who has been in the home in the past*

<b>Name</b>	<b>Relation to child</b>	<b>Current age (or age at death)</b>	<b>Describe how relationship has impacted child</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Child's parent's relationship with each other \_\_\_\_\_

Any significant event(s) that impacted child? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any significant family members with current or past depression, bipolar disorder, anxiety disorder, obsessive compulsive disorder, ADHD, substance abuse problems, suicide, trouble with the law, developmental disorders, or any other mental condition? **Yes No** If yes, please list.

Name	Relationship to child	Condition	Current Mental Status

If any family members, friends, pets, or other important creature is/are deceased, please list below.

Name	Relationship	Age at Death	Cause of Death	Impact on child

**Trauma/Abuse History**

Please indicate if you experienced any of the following forms of abuse:

Physical \_\_\_ Sexual \_\_\_ Neglect \_\_\_ Emotional \_\_\_ Domestic violence \_\_\_ Witnessing abuse \_\_\_

Any traumatic event(s) that affected your child \_\_\_\_\_

**Past relationships (includes important adults, friends, dating (if child is older))**

Briefly describe any significant relationship history \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Present relationships**

Briefly describe your child's current relationships with the following:

Friends \_\_\_\_\_

Family members \_\_\_\_\_

Extended family \_\_\_\_\_

Romantic interests (if applicable) \_\_\_\_\_

List any strengths or concerns you have about your child's social interactions \_\_\_\_\_  
\_\_\_\_\_

**Treatment:**

Have your child ever received counseling before? **Yes No** If yes, when? \_\_\_\_\_

Counselor's name/location \_\_\_\_\_

What was helpful? \_\_\_\_\_

What was not helpful? \_\_\_\_\_

*It is helpful for me to know what past experiences has been and if you need more information about what counseling can be.*

Any previous mental health diagnoses? \_\_\_\_\_

Has your child ever been hospitalized for mental health or substance abuse reasons? \_\_\_\_\_ If yes, please complete:

- Hospitalization dates \_\_\_\_\_ Hospital \_\_\_\_\_  
Reason \_\_\_\_\_ Outcome \_\_\_\_\_
- Hospitalization dates \_\_\_\_\_ Hospital \_\_\_\_\_  
Reason \_\_\_\_\_ Outcome \_\_\_\_\_

Have your child ever attempted suicide? \_\_\_\_\_ If yes, when? \_\_\_\_\_

Please describe circumstances and method: \_\_\_\_\_  
\_\_\_\_\_

Has your child ever self-harmed or intentionally taken risks likely to cause significant injury? \_\_\_\_\_ If yes, please describe:  
\_\_\_\_\_  
\_\_\_\_\_

**Physical wellness**

Circle child's present state of health: **Excellent** **Good** **Fair** **Poor**  
Any diagnosed medical conditions \_\_\_\_\_

Any current medications? **Yes** **No** If Yes, please list below.

<u>Medication</u>	<u>Dosage</u>	<u>Name of Prescriber</u>	<u>Date started</u>	<u>Reason for taking the medicine</u>

Please check if your child has experienced the following during the past six months:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Severe headaches                          | <input type="checkbox"/> Frequent tiredness            | <input type="checkbox"/> Severe backaches/body aches              |
| <input type="checkbox"/> Frequent trouble sleeping                 | <input type="checkbox"/> Stomach problems              | <input type="checkbox"/> Dizziness or fainting                    |
| <input type="checkbox"/> Eating Problems                           | <input type="checkbox"/> Panic attacks                 | <input type="checkbox"/> Seizures                                 |
| <input type="checkbox"/> Hearing voices                            | <input type="checkbox"/> Hallucinating                 | <input type="checkbox"/> Fearfulness                              |
| <input type="checkbox"/> Excessive worry                           | <input type="checkbox"/> Nervous                       | <input type="checkbox"/> Sadness                                  |
| <input type="checkbox"/> Significant change in contact with others | <input type="checkbox"/> Feeling guilty                | <input type="checkbox"/> Discouragement or hopelessness           |
| <input type="checkbox"/> Significant change/loss in friends        | <input type="checkbox"/> Anger/irritability in teens   | <input type="checkbox"/> Hurting self                             |
| <input type="checkbox"/> Large weight gain/loss                    | <input type="checkbox"/> Physically hurting others     | <input type="checkbox"/> Trouble concentrating                    |
| <input type="checkbox"/> Speeding thoughts                         | <input type="checkbox"/> Unable to relax/sit still     | <input type="checkbox"/> Loss of interest in enjoyable activities |
| <input type="checkbox"/> Not completing important work/tasks       | <input type="checkbox"/> Easily startled               | <input type="checkbox"/> Thoughts about dying/death               |
| <input type="checkbox"/> Difficulty remembering past events        | <input type="checkbox"/> Not feeling happy as expected | <input type="checkbox"/> Flashbacks of past events                |

Other problems not listed (Please specify): \_\_\_\_\_

**Chemical use** (This is important to consider before diagnosing a child/teen due to the impact it can have on behavior)

- Amount of caffeinated drinks (tea, soda, coffee)? \_\_\_\_\_ energy drinks? \_\_\_\_\_
- Any medications or other substance to get to sleep? \_\_\_\_\_ stay awake? \_\_\_\_\_
- Any tobacco/nicotine use (smoked, chewed, vaping)? \_\_\_\_\_
- Any known beer, wine, or other alcohol use? \_\_\_\_\_  
Any known huffing or other substance use? \_\_\_\_\_
  - Family history of alcohol/substance abuse or addiction? **Yes No**
  - Others around child that abuse alcohol, drugs, or medications? **Yes No**
  - Does your child have access to alcohol, medications, or drugs? **Yes No**
  - Does your child have friends that use alcohol, drugs, or abuse medications? **Yes No**

Concerns: \_\_\_\_\_

**Legal/School disciplinary/Academic intervention**

- Is your child attending this appointment for any legal reason(s) or requirement(s)? **Yes No** If yes, please explain: \_\_\_\_\_
- Any legal history? \_\_\_\_\_
- Any school detention, suspension, or expulsion history? \_\_\_\_\_
- Any 504/IEP plans or behavioral interventions at school? \_\_\_\_\_

## Counseling planning

### Stressors

Please check any stressors that are a part of your child's life.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Personal illness   | <input type="checkbox"/> Health problem in family | <input type="checkbox"/> Money problems          |
| <input type="checkbox"/> Lack of employment | <input type="checkbox"/> Parent discord           | <input type="checkbox"/> Death of family member  |
| <input type="checkbox"/> Parent divorce     | <input type="checkbox"/> Parent separation        | <input type="checkbox"/> Sexual abuse            |
| <input type="checkbox"/> Physical abuse     | <input type="checkbox"/> Discrimination           | <input type="checkbox"/> Death of a friend       |
| <input type="checkbox"/> Loneliness         | <input type="checkbox"/> Unhappy childhood        | <input type="checkbox"/> Rejection from others   |
| <input type="checkbox"/> New baby           | <input type="checkbox"/> Parent remarriage        | <input type="checkbox"/> Educational problems    |
| <input type="checkbox"/> School change      | <input type="checkbox"/> Teacher conflict         | <input type="checkbox"/> Bullied by others       |
| <input type="checkbox"/> Unmet basic needs  | <input type="checkbox"/> Lack of health care      | <input type="checkbox"/> Bullying others         |
| <input type="checkbox"/> Victim of crime    | <input type="checkbox"/> Conflict with siblings   | <input type="checkbox"/> Conflict with parent(s) |
| <input type="checkbox"/> Recent move        | <input type="checkbox"/> Other (specify) _____    |  |

### Your child's needs

1. What are your reasons for seeking therapy? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Anything your child wants to get out of therapy? *(parent and child often have different expectations, but I will ask more about this in the first session)* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. When did this these reasons become a problem? \_\_\_\_\_
3. What made you decide to seek therapy now? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. How much do you feel your child needs counseling right now?

**i. Extremely      Very much      Somewhat      Not very much      Not at all**

5. Any challenges that would affect your child's counseling progress? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Do you or your child have any questions or concerns about counseling? Talking about these in the session can help you and/or your child feel more comfortable. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. What else do you think is important for me to know? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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## Financial Policies Statement

Thank you for choosing me as your Mental Health Care Provider. I am committed to providing excellent mental health care for you. The following is a statement of my financial policy, which I require that you read and sign prior to beginning any treatment. If you have any questions about my financial policy please do not hesitate to ask me.

### PROFESSIONAL FEES

- \$125.00 per 50 minute session for individuals, couples, or families.
- \$175 per 60 minutes for any preparation and/or attendance at court proceedings including my requested appearance is by another party
- \$125 per hour for written reports and prepared documents
- Telephone consultations that exceed 5 minutes will be prorated at \$125.00 per hour. If you need to contact me between sessions, please leave a message on my voice mail or email me, and I will reply as soon as I can.

### PAYMENT

Full payment is due at the time of each service. I accept cash, personal checks, most credit cards, or money orders. A \$25.00 service charge will be assessed for any returned checks.

### CANCELLATIONS AND MISSED APPOINTMENTS

Please make every effort to keep your appointment time. Reminder calls may be provided, but your scheduled session is reserved for you unless you or I make changes. 48 hours notice for canceling appointments is preferred. **Unless I hear from you at least 24 hours in advance, I will unfortunately charge you the full fee (\$125.00) for a missed or uncanceled appointment.** Cancellations can be made by leaving me a message at (208) 376-5683 ext. 376 or the general business line at (208) 376-5683.

**Initials of person responsible for payment:** \_\_\_\_\_ **Date of initials:** \_\_\_\_\_

*\*Your initials indicate that you understand this policy and agree with this policy.*

### INSURANCE

- As a courtesy to you, I will file a claim with your insurance provider. This does not guarantee either full or partial payment. You are fully responsible for all charges regardless of your insurance benefits.
- Accurate and updated information is required at the time of service to file a claim with your insurance provider.
- Your insurance provider will determine what services are considered "non-covered," "reasonable and necessary," or "out of network." They will also determine what applies to any "deductible" or what your "co-pay" amount will be. Your insurance policy is a contract between you and your insurance provider. My access to this information is often limited.
- It is your responsibility as the policy holder to know if/when your insurance provider requires prior authorizations.
- Your insurance provider may require your confidential information to use your insurance policy for my services.

### EMPLOYEE ASSISTANCE PROGRAM (if applicable)

Name of your EAP: \_\_\_\_\_ Authorization #: \_\_\_\_\_ # of sessions: \_\_\_\_\_

### INSURANCE/THIRD PARTY PAYERS

\*\*\*A copy of your insurance card and identification is required before your first session begins.

#### A. BILLING AUTHORIZATION

I authorize the release of any information necessary to process my claim to Third Party Payers that provide financial reimbursement for requested services of Kimberly Ledwa, LCPC, ACADC. I authorize direct payment to my service provider from my Third Party Payer. I permit a copy of this form to be used in place of the original.

Authorized person's signature: \_\_\_\_\_ Date \_\_\_\_\_

#### B. PAYMENT AGREEMENT

I have read the financial policy. I understand and agree to comply with this financial policy. I have been given a copy of this policy. I agree to pay for all services rendered and any legal expenses incurred should my account be turned over to another party for collection.

Authorized person's signature: \_\_\_\_\_ Date \_\_\_\_\_

Authorized person's printed name: \_\_\_\_\_

#### C. INSURED PERSON FOR POLICY:

Minors are typically under an adults's insurance policy. Please provide the following to allow us to be able to bill your insurance provider:

Insured person's name: \_\_\_\_\_ Your relationship to insured person: \_\_\_\_\_  
Insured person's employer: \_\_\_\_\_ Insured person's date of birth: \_\_\_\_\_ Insured person's address: \_\_\_\_\_

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## **Informed Consent and Disclosure Statement**

### **Confidentiality**

In compliance with applicable Federal Laws and regulations, along with the State of Idaho statutes (Chapter 34, Title 54-3410B, Idaho Code), all the information obtained during your counseling sessions will be kept confidential, as required by law. Information gathered during your counselling sessions will not be revealed to anyone beyond the purposes of your authorized billing information except in the following situations when disclosure as required by law:

- When there is reasonable suspicion or report of abuse to vulnerable populations, including children, elderly persons, and individuals who are unable to advocate for themselves.
- When you present serious and foreseeable harm to yourself or others.
- If we receive a subpoena, court order, or as part of legal proceedings which may include but is not limited to legal complaints filed by you against your provider.
- In specific cases of law enforcement emergency for national security issues.

### **Counseling Process**

I am dedicated to giving you the best care that I can. It is my conviction that for effective counseling to occur, a partnership between the counselor and client must exist. As such, you will be expected to be actively involved in choosing the course of your treatment. While specific outcomes for your counseling goals are not guaranteed, I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards of practice as adopted by the American Counseling Association and the Idaho Counselor Licensing Board.

My therapeutic orientation is Adlerian therapy. With this approach, I effectively integrate other techniques from many treatment modalities including cognitive-behavioral, existential, solution-oriented, client-centered, behavioral, and family systems. Depending upon the challenges you face, your length of treatment will vary. However, this is your process and you control many aspects of this. You may end our counseling relationship at any point, and I will be supportive of your decision. If counseling is successful, you will feel that you are able to face life's challenges in the future without my support or intervention. At some time during the counseling process, you may feel a variety of unsettling emotions. Be aware that this is normal. Please feel free to bring up any uncomfortable counseling experiences with me. In the event you are dissatisfied with my services for any reason, please let me know.

**Client Rights:** You have the right to:

1. Accept or refuse any treatment and understand the implications of refusal
2. Receive fair & equal treatment in all circumstances regardless of your age, race, gender, sexual orientation, or religion
3. Be treated with respect, consideration, and dignity in a safe environment
4. Privacy of care
5. Be informed of my training and qualifications, including the limits and restrictions of my qualifications
6. Receive accurate, easily understood information about your mental health concerns and the treatment you receive
7. Be informed of the purpose, goals, techniques, procedures, limitations, potential risks, and benefits to treatment
8. Ask questions about your treatment
9. Work with me on a treatment plan that you are comfortable with and will adhere to
10. Request to be referred to another therapist
11. Confidentiality of your records and make written changes to a release of your information
12. Request that your records be sent to another professional or agency. Your written request will be fulfilled with promptness, provided there is no outstanding balance on your account
13. File a complaint without retaliation

**Client Responsibilities:** You are responsible for:

1. Providing an accurate information regarding your health and mental health history
2. Being an active participant in your care
3. Asking questions for clarification if you do not understand your treatment plan or other aspects of treatment
4. Following the treatment plan
5. Keeping your appointments and arriving on-time
6. Canceling or rescheduling appointments as far in advance as possible so that time can be used to treat others
7. Communicate with your provider if your symptoms worsen or does not follow the expected course
8. Providing useful feedback about services and policies
9. Providing accurate information for payments and billing
10. Fulfilling your financial obligations and pay for care as promptly as possible
11. Being involved as a parent in the therapy of your child when a child is a minor

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services at:

*Office for Civil Rights Region 10  
U.S. Department of Health and Human Services  
2201 Sixth Avenue - M/S: RX-11 Seattle, WA 98121-1831  
Phone (800) 368-1019, Fax (206) 615-2297, TDD (800) 537-7697*

**Provider Rights:** I have the right to:

1. Establish and maintain mutually respectful relationships with my clients
2. Terminate a relationship with a client if that client's care is outside my scope of practice, if the client is a safety concern, or if client's needs/care creates ethical dilemmas in providing professional standards of care. In these cases, clients will be provided appropriate referrals that would best meet their needs.

**Provider Responsibilities:** I am responsible for:

1. Adhering to all statutes, licensing board rules, and codes of ethics in my profession
2. Present clients with documents related to my professional qualifications upon request
3. Provide quality services and involve clients in their plan development and evaluation of treatment goals
4. Ensure confidentiality of client's clinical information whenever possible
5. Inform clients of my qualifications, education, areas of expertise, and to practice within those standards
6. Respect clients regardless of client's age, race, ethnicity, gender, sexual orientation, religion, and socioeconomic status

**Our Professional Counseling Relationship**

Our counseling relationship is a professional relationship. I will assist you in exploring and resolving difficult life issues. Our sessions may be very intimate. However, it is important that our relationship remain professional and limited to the paid session you have with me. You will be best served if our relationship remains professional and focus exclusively on your concerns. Additionally, I will maintain your confidentiality outside of our counseling sessions if we do happen to meet in a public setting.

**Financial Policy**

Please read and sign the financial policy. Payment in full is expected at each visit. Please ask if you have any questions.

**Cancellations, and Missed Appointments**

Please make every effort to keep your appointment time that you have reserved. 48 hours notice for canceling appointments is preferred. Reminder calls may be provided to assist you, but this is not guaranteed. Your cooperation with this practice respects my time and allows me to use that appointment time for seeing other clients in need. **Unless I hear from you at least 24 hours in advance, I will unfortunately charge you the full fee ( \$125.00 ) for a missed or uncancelled appointment.** Cancellations can be made by calling (208) 376-5683 ext. 376 to leave a message on my confidential voice mail.

**Emergency and Crisis Availability**

You need to be aware that Kimberly Ledwa, LCPC, ACADC does not provide emergency services, and that in an emergency situation, you are advised to contact your local community mental health center, your physician, emergency room, a crisis counseling hotline, or 911.

Important local crisis numbers are:

- Mobile Crisis Line 208-334-0808
- Hays Shelter Home 208-322-2308
- St Alphonsus's Behavioral Health 208-367-2175
- Suicide Hotline 1-800-273-8255
- Women's and Children's Alliance 208-343-7025.

My signature signifies that I have read, I understand, and I accept these conditions and policies, and that I agree to enter therapy. I have been given a copy of these policies. I agree to pay for all services rendered and any legal expenses necessary for collection. I authorize and request that Kimberly Ledwa, LCPC, ACADC provides psychological examinations, treatment and/or diagnostic procedures which may now or during the course of my care as a client are advisable. The frequency and type of treatment will be decided between my counselor and me. I understand that the purpose of these procedures will be explained to me and be subject to my verbal agreement. I understand that there is an expectation that I will benefit from counseling but there is no guarantee that this will occur. I understand that maximum benefit will occur with consistent attendance and that at times I may feel conflicted about my therapy as the process can sometimes be uncomfortable. I have read and I fully understand this Informed Consent and Disclosure Form. By signing this, I am giving my consent for treatment.

\_\_\_\_\_  
Print Client Name (Age 14 or older must complete)

\_\_\_\_\_  
Client Signature (Age 14 or older must sign)

\_\_\_\_\_  
Client's parent/guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Counselor Signature

\_\_\_\_\_  
Date

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## RELEASE OF CONFIDENTIAL INFORMATION

*This form is optional and allows Kimberly to share only the information you indicate.*

Client Name \_\_\_\_\_ DOB \_\_\_\_\_

Other names used \_\_\_\_\_

I, \_\_\_\_\_, authorize Kimberly Ledwa., LCPC, ACADC to

disclose to or  request from \_\_\_\_\_

### The following information:

- |   |   |
|---|---|
| <input type="checkbox"/> Diagnosis and Treatment Plan | <input type="checkbox"/> Psychological Evaluation                                       |
| <input type="checkbox"/> Admit and Discharge Summary  | <input type="checkbox"/> Psychiatric Evaluation <input type="checkbox"/> Social History |
| <input type="checkbox"/> Consultation Notes           | <input type="checkbox"/> Emergency Room Report (date) _____                             |
| <input type="checkbox"/> Lab Reports                  | <input type="checkbox"/> Substance Abuse Evaluations                                    |
| <input type="checkbox"/> Legal History                | <input type="checkbox"/> Probation/Parole/H&W Stipulations                              |
| <input type="checkbox"/> Other (specify) _____        |   |

### The purpose or need for such disclosure:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Diagnosis and Treatment Plan | <input type="checkbox"/> Determine eligibility for services | <input type="checkbox"/> Discharge Plan |
| <input type="checkbox"/> Coordinate Care              | <input type="checkbox"/> Other (specify) _____              |   |

I am aware that the specific type of information requested, as well as the benefit and disadvantages of releasing the information, if known. Also, I am informed that treatment services are not contingent on my decision concerning this release. I understand that my records are protected under the Federal Confidentiality Regulations (American Counseling Association, B.1.a and Federal Drug and Alcohol Regulations 42 CFR Part 2) and HIPAA and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that the information disclosed pursuant to the authorization may potentially be redisclosed by the recipient and may no longer be protected by state and federal privacy laws.

If an agency has taken an action on my behalf, which relies upon this release, I understand that I will abide by the stipulations of that action. I also understand this consent is subject to revocation at any time and unless otherwise specified continues for six months after the end of treatment. I release Kimberly Ledwa, LCPC, ACADC from any and all responsibility and liability concerning the release of information I have consented to above. I permit a copy of this release to serve as original.

I understand that my health information may include information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information unless I have crossed it out and initialed here. \_\_\_\_\_ Initials

Client/Parent/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_  
signature

Witness \_\_\_\_\_ Date \_\_\_\_\_

**NOTE TO AGENCY/PERSON IN RECEIPT OF INFORMATION:** This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42CRF Part 2 and HIPAA) prohibits you from making any further disclosure of it without the 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.