artisan
COUNSELING

AUTHORIZATION FOR RELEASE OF INFORMATION

I, (Client Name) _____ and date of birth _____, hereby authorize Artisan Counseling, LLC and (Counselor Name) _____, at (757) 503 – 2819 to disclose to and/or obtain from the below person(s) or organization:

Name:		Company/Agency:	
Title:		Phone Number:	
Email:		Fax:	

TYPE OF INFORMATION TO BE DISCLOSED					
☐	Evaluations	☐	Diagnosis	☐	Treatment Plan
☐	Course of Treatment	☐	Medical/Hospital Records	☐	Psychological/Medical Test Results
☐	Psychotherapy Notes	☐	Intake/Discharge Documents	☐	SUD Treatment Information
☐	Other (List):				

PURPOSE OF SUCH DISCLOSURE					
☐	Ongoing Treatment	☐	Medical Care	☐	Consultation
☐	Evaluation	☐	Transfer	☐	Legal Issues
☐	Coordination of Care	☐	Health Benefit Utilization	☐	Consultation
☐	Other (List):				

EXPECTATIONS OF DISCLOSURE

The designated information about me ☐ **may or** ☐ **may not** be transmitted by fax, electronic email or other electronic file transfer mechanisms. _____ (Artisan Counseling) and the above designated person ☐ **may or** ☐ **may not** discuss by telephone the content of the information released.

This consent is in effect until _____ or 90 days after the closure of counseling services. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already taken place.

I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential in the case of licensed counselors (LPC) and social workers (LCSW) except as provided in section 12.43.218 CRS and except for certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children.

I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under HIPAA privacy regulations.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

Client Signature:		Date:	
Parent/Guardian (if applicable) Signature:		Date:	
Counselor Signature:		Date:	