chapters counseling
as chapters of life unfold

CONSENT TO RELEASE OR RECEIVE CONFIDENTIAL INFORMATION

Client Name_____ Address_____

Date of Birth:_____ Phone #_____ City, ST, Zip_____

I Hereby Authorize and Direct That:

Carolyn Coffey will: ☐ ***Release information to***

Fax # (402) ☐ ***Receive information from***

Name_____Address_____

Fax #_____Phone #_____

THE INFORMATION REQUESTED IS NEEDED FOR THE FOLLOWING PURPOSE:

_____

AND, SUCH DISCLOSURE SHALL BE LIMITED TO THE FOLLOWING SPECIFIC INFORMATION:

_____***Medical:*** Discharge Summary, History and Physical
_____***Psychological***: Evaluation, Diagnosis, Treatment Plan, Case Notes
_____***Social:*** Social History
_____***Educational:*** Transcripts and Test Results
_____***Substance Abuse:*** Chemical Dependency Evaluation/Treatment Results/Treatment Plan
_____***Any Pertinent Information***

- I understand that this authorization will expire on ___/___/___(DD/MM/YR) or 30 days after my termination from treatment. **INITIALS_____**

- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation. **INITIALS_____** .

Warning: The confidentiality of this information is protected by Federal Law (42CFRII). No further disclosure of this information is allowed without the above-named person's written consent specifying release of this information in accord with Federal regulations.

If signed by person other than patient: My relationship to the patient and my authority to consent and direct this authorization is as follows: _____

Signed:_____ *Date*: _____

Witness: _____ Date: _____

NOTE: Maintain original in client file

YOU MAY REFUSE TO SIGN THIS RELEASE Client is to receive a copy of the signed form.