**AUTHORIZATION FOR RELEASE OF INFORMAITON**

**ALL ELEMENTS ARE REQUIRED PRIOR TO INFORMATION BEING RELEASED**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1: | Client Name: |  | DOB: |  | SSN: |  |
|  |
| 2: | I consent for AR Nextstep Counseling Services, located at 2315 E. Matthews, Jonesboro, AR 72401, to: |
|  |  | **Release my records from:** |  | **Release my records to:** |  | **Allow verbal communication with:** |
|  |  |  |  |  |  |  |
| 3: |  | Located at |   |  |  |  |
|  | Name of Entity/Person |  | Full Address City State Zip |
|  |  |  |  |
| 4: | SPECIFIC INFORMATION REQUESTED/TO BE RELEASED (please check all that apply) |
|  | School: |  | DCFS: |  | Other: |
|   | Grade Reports |  | DCFS Case Plan |  | Intake/Psychosocial History |
|   | Conduct Reports |  | Court Orders |  | Psychiatric Eval/MD Notes |
|   | Attendance Records  |  | Alcohol/Drug Tx |  | Therapy Notes |
|   | IEP (if applicable) |  | Medical (physical) |  | Psychological Testing |
|   | Psychoeducational Testing |  | Other:  |  | Treatment Plan/Updates |
|  |  |  |  |  | Discharge Summary |
|   | Other information requested to be released: |  |
|  |  |  |  |  |  |
|  | List dates of service: |  |
|  |  |  |  |  |  |
|   | Authorization for the above listed person to accompany my child to their appointments. |
| 5: | The purpose of this release of information is: |
|  | Continuity of care |  | Legal Reasons |  | School/Educational |
|   | Disability |  | Insurance |  | Other: |  |
| 6: | I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. |
|  |  |
| 7: | I understand that AR Nextstep Counseling Services may charge for the costs of copying the information to be released and I understand that AR Nextstep Counseling Services has up to 30 days to retrieve and copy the medical record. |
|  |  |  |  |  |  |
| 8: | I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed under this authorization. |
|  |  |  |  |  |  |
| 9: | I understand that I may revoke this authorization in writing at any time by delivering a copy of my revocation to AR Nextstep Counseling Services except to the extent that action has been taken in reliance on this authorization. This authorization expires\_\_\_\_\_\_\_\_\_ (mm/dd/year). |

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Client’s Signature Date Parent/Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Date Witness Signature Date