**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