Authorization for Release of Confidential Information

Client Name	Client Name

I authorize Personal and Family Counseling to disclose to and/or obtain from:

Name and Relationship of Contact	Contact Information (if needed)	Client Initials
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Description of Information to be Disclosed

I understand that by signing this release I authorize Personal and Family Counseling to disclose my health information to the persons, classes of persons, and entities listed above and that any health information or other confidential information in the possession of the persons, classes of persons and entities listed above may be disclosed to Personal and Family Counseling.

This authorization is valid until _____ (fill in date) or until three months after my file is closed at Personal and Family Counseling.

The types of information that Personal and Family Counseling may share includes, but is not limited to:

> Assessment, Diagnosis, Psychosocial Evaluation, Psychological Evaluation, Treatment Plan or Summary, Current Treatment Update, Medication Management Information, Presence/Participation in Treatment, Medical Information, Educational Information, Discharge/Transfer Summary, Continuing Care Plan, Progress in Treatment, Demographic Information, Psychotherapy Notes

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. This disclosure of information may also be used for the collection of payment.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to [Insert Name] at [Insert Contact Information]. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

_____

Signature of Client Date

_____

Signature of Client, Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____

Signature of Witness Date

If you have no history of drug or alcohol abuse you can STOP here. If you have a history of drug or alcohol abuse OR you may receive services for drug or alcohol abuse at Personal and Family Counseling then please read the next page.

Authorization for Release of Confidential Information - Continued

Records pertaining to substance abuse are entitled to heightened protections under federal law. Therefore, we cannot disclose them to anyone for any reason other than those specified in the HIPAA Notice of Privacy Practices without your written consent. This form is for you to authorize the disclosure to multiple parties for multiple purposes. This consent to disclosure of your substance abuse records is completely up to you.

Client Name _____ Client Name _____

I request and authorize Personal and Family Counseling to disclose: (kind and amount of information to be disclosed)

_____

_____

For example: *My records pertaining to substance abuse treatment or the dates I have attended counseling at Personal and Family Counseling*

To: (Name or title of person(s) or organization(s) to which disclosure is to be made)

_____

_____

For example: *Your health insurer, your doctor, your ecclesiastical leader, your employeer, or family members*

For: (The purpose(s) of the disclosure)

_____

_____

For example: *To obtain insurance benefits, medical treatment, employment reasons, or family support*

_____

Signature of Client Date

_____

Signature of Client, Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____

Signature of Witness Date

Termination

This consent can be terminated at any time except to the extent that Personal and Family Counseling has already taken action in reliance on it.

Consent will be terminated on: (Specific date, event, or condition)

_____

If left blank, consent will terminate on the last day reasonable necessary to accomplish the intended purpose of the disclosure

Notice to Accompany Disclosure

This information has been disclosed to you from records protected by Federal confidentiality rules 42 CFR part 2. The federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Feder[redacted]ules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. 42 CFR.