Release of Information Consent

Client's Name: _____

Address: _____ City: _____ State: _____ Zip: ____

Phone: _____ DOB: _____

I, _____ , authorize _____ to:

____ (send) __ (receive) the following _____ (to) _____(from)

Name: _____

Address: _____ City: _____ State: _____ Zip: ____

Phone:_____ ____ Fax:_____

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR *PSYCHOTHERAPY NOTES.

___ Academic testing results
___ Behavior programs
___ Progress reports
___ Intelligence testing results
___ Medical reports
___ Letter
___ Psychological reports
___ Psychological testing results
___ Service plans
___ Summary reports
___ Vocational testing results
___ Entire record, except progress notes
___ *Psychotherapy Notes
_____Other, specify_____

The above information will be used for the following purposes:

___ Planning appropriate treatment or program
___ Continuing appropriate treatment or program
___ Determining eligibility for benefits or program
___ Case review _____ Updating files
___ Other (specify) _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered
by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to client: ___Self __Parent/legal guardian __
Other (describe)_____

Client's Signature:_____ Date: _____/_____/____

Parent/guardian/personal representative (if applicable)

Signature: _____ Date: ___/__/_____

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Witness (if client is unable to sign)

Signature: _____ Date: ___/__/_____