FAMILY CONCERN COUNSELING

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Revised: July 2019

Consent for Release of Information | CONFIDENTIAL

I authorize release of information to be disclosed between parties listed.

Client Name [please print] _____

Birthdate _____ Other Names used in treatment [if any] _____

BETWEEN...

Family Concern Counseling

Counselor Name [please print] _____

Phone: _____ Email: _____

Professional Entity

Name of Professional [please print] _____

Phone: _____ Email: _____

FAX: _____ Relationship to Client: _____

Check all types of information to be disclosed:

- ❑ To verify treatment:
  - ❑ Treatment dates ❑ Discharge status
- ❑ Behavioral Health Summary
- ❑ Medical history
- ❑ Physical Exam
- ❑ Lab Test Results
- ❑ Doctor's Notes
- ❑ Chemical Dependency assessment
- ❑ Psychologist assessment
- ❑ Psychiatrist assessment
- ❑ Discharge Summary
- ❑ Continuing Care:
  - ❑ Attendance ❑ Continuing Care Plan
- ❑ Other _____

Information and records requested may include reference to my HIV/AIDS status:

- ❑ I do want this included
- ❑ I do not want this included
- ❑ NOT APPLICABLE

Why the information is needed:

- ❑ Legal (case type)
- ❑ Benefits/insurance related
- ❑ Other _____

I understand that:

- My health information is protected by federal regulations (Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and/or HIPAA, 45 CFR) and state privacy laws, and disclosure is allowed only with my authorization except in limited circumstances described in Family Concern Counseling's Privacy Notice. I understand that I have a right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws.
- I can revoke this authorization at any time except to the extent that action has been taken in reliance on it. Family Concern Counseling's Privacy Notice outlines the procedure for revocation. This authorization will expire in one year from the date I sign it unless I request an earlier expiration in writing.
- For disclosures other than for treatment, payment and health care operations purposes, treatment may not be conditioned on my agreement to sign an authorization (unless I am receiving care solely to create protected health information for disclosure to a third party [42 CFR 164.508(b)(4)(iii)].
- Communications resulting from this authorization will reveal that I received services at Family Concern Counseling.
- Federal confidentiality regulations (42 CFR Part 2) prohibit redisclosure of information from alcohol and drug abuse patient records. However, HIPAA requires Family Concern Counseling to notify me of the potential that information disclosed pursuant to this authorization might be redisclosed by the recipient and is no longer protected by the HIPAA regulations.
- This authorization may be used by Family Concern Counseling owned or managed programs upon transfer of my care to them.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

❑ Client ❑ Parent/Guardian Phone: _____ Email: _____