Consent for Release of Information TO *Family Concern Counseling*

Revised: 9/2013

2004 Valparaiso Street, Valparaiso, Indiana 46383 ▪ 219-477-5646 ▪ FAX 219-476-3190 ▪ info@familycounsel.org ▪ www.familycounsel.org

CONFIDENTIAL

Patient Name [please print] ____

Birthdate ____________________Other Names used in treatment [if any] ____________________

I authorize ______________________________ to disclose information about me **TO**:

Family Concern Counseling, 2004 Valparaiso Street, Valparaiso, IN 46383-3138

Relationship to Patient:__________________________________

Check all types of information to be disclosed to above party:

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

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 (specify 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 my of the potential that information disclosed pursuant to this authorization might be redisclosed by the recipient and is no longer protected by the HIPAA rules.
- 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:__________________

Consent for Release of Information

FROM *Family Concern Counseling*

TO other Professionals/Organizations

Revised: 9/2013

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CONFIDENTIAL

Patient Name [please print] ______________________________

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

I authorize Family Concern Counseling to disclose information about me **TO**:

Name ______________________________

Address ______________________________

City ______________________ State ______________ Zip ______________

Phone – Phone ______________________ FAX ______________________

Relationship to Patient: ______________________________

Check all types of information to be disclosed to above party:

- ❑ To verify treatment: ❑ Treatment dates ❑ Discharge status
- ❑ Chemical Dependency Assessment
- ❑ Psychologist assessment Other: ______________________
- ❑ Discharge Summary
- ❑ Continuing Care: ❑ Attendance ❑ Continuing Care Plan
- ❑ Other (specify) ______________________________

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

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Why the information is needed:
- ❑ Legal (specify case type) ______________________
- ❑ Benefits/insurance related
- ❑ Other ______________________________

I understand that:

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Parent/Guardian Signature: ______________________________ Date: ______________________

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