RELEASE OF INFORMATION

Client's Name:

_____

Address: _____City: _____ State: _____ Zip: _____

Phone: _____ DOB: _____

I, _____, authorize Integrative Counseling Services to **send to/receive from** (circle one or both)

Name: _____ Phone: _____

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

Relationship: Family Member PCP Supports Coord./Case Manager Residential Provider Day Program Other: _____

Information to be released:

_____ Treatment Plan(s) _____ Psychological testing results _____ Behavior plans/data _____ Mental Status Exams _____ Progress reports/letters _____ Session Summary Reports
_____ Comprehensive Assessment _____ Entire record, except progress notes _____ Personality profiles _____ Written and Oral communication _____ Psychological reports _____ Others, specify _____

The above information will be used for the following purposes:

_____ Planning appropriate treatment or program _____ Continuing appropriate treatment or program _____ 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 that the information disclosed to the recipient may not be pro- tected 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 (some states very, usually 1 year) this consent automatically expires. I have been informed what information will be given, its pur- pose, 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 ____Legal representative ____Other (describe) _____

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.

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

Parent/guardians/legal representative (if applicable) Signature: _____ Date ____/ _____/ ____

Witness #1 (if client is unable to sign) Signature: _____ Date ____/ _____/ ____

Witness #2 (if client is unable to sign) Signature:_____ Date ____/_____/ ____

Therapist Signature: _____ Date ____/_____/_____