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 to Client: Family Member/Spouse PCP SC/Case Manager Residential/Day Program School Psychiatrist Probation/Parole Attorney/Advocate Transportation D/A Provider Other: _____________________

Information to be released:

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

The above information will be used for the following purposes:

______ Planning appropriate treatment or program
______ Continuing appropriate treatment or program
______ Emergency Contact only
______ 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 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 (some states very, usually 1 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 ____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 ____/_____/ _____