Consent for Release of Information

Client's Name: ____
Address: _______________________ City: ______________ State: _____ Zip: ____________
Phone: ___________________________ DOB: _____________________

I______________________________, authorize **Counseling Connection,llc,** to:

_________ Send or receive the following information (from)
Name: ____
Address: _______________________ City: ________________ State: _____________Zip: ______

- [ ] Academic testing result
- [ ] Behavior programs
- [ ] Progress reports
- [ ] Intelligence testing results
- [ ] Medical reports
- [ ] Personality profiles
- [ ] Psychological reports
- [ ] Psychological testing results
- [ ] Service plans
- [ ] Summary reports
- [ ] Vocational testing results
- [ ] Entire record, except progress notes
- [ ] Psychotherapy Notes (will not be shared)

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 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; _____Personal 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/guardian/personal representative (if applicable)
Signature: ____Date:___________________________
Witness (if client is unable to sign)
Signature: ____Date:___________________________