Top Level Counseling and Testing Center Authorization for Disclosure of Information

_____

Individual/Patient Date of Birth Social Security Number or Case Number

_____

Address

I, _____ ,
hereby authorize the release and disclosure of the following clinical, mental, and/or therapeutic records for the following purpose(s):

[ ] Authorization to release information regarding counseling and therapy care and treatment.

[ ] Authorization to release information regarding mental health treatment

[ ] Authorization to release information held under the Drug Office and Treatment Act of 1972 (PL-92255) and the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act Amendments of 1974. I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

[ ] Authorization to release information related to Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

To Disclose to:

Name of Provider/Person:_____

Address: _____

Phone/Fax: _____

To Disclose from:

Name of Provider/Person: _____

Address: _____

Phone/Fax: _____

Specific information to be released (client's initials to approve release):

_____ Assessments and evaluations (specify:) _____ Psychosocial history

_____ Psychiatric Evaluation _____ Discharge summary

_____ Summary of treatment _____ Psychotherapy Notes

Correspondence (specify): _____

Other (specify): _____

Description of the purpose of the use and/or disclosure (check only what is applicable):

_____ continuity of care _____ referral

_____ consultation _____ personal

_____ other (please describe): _____

I do not authorize the release of the following information:

_____

This authorization will expire within one year from date of this authorization unless I otherwise specify. I desire this authorization to be in effect until _____.

I understand that I may revoke this authorization in writing at any time, except for actions that have already been taken prior to this request. I also understand that a written revocation must be signed and dated later than the date on this authorization.

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

Clinician's Name: _____ Signature: _____ Date: ____/____/____