Authorization to Release Confidential Records and Information

Client Name: _____ DOB: _____

I hereby authorize ___Riversage Family Counseling_ to release or receive confidential records regarding myself or the individual named above to or from on the line below:

Name of person or organization (please include name and contact info):_____

_____

This disclosure of information is required for the following purpose(s): Please initial the appropriate line(s).

____ Continuity of Care
____ Service Planning
____ At the Client's request

The disclosure shall be limited to requesting/releasing the following types of information:

____ Summary of Record
____ Social History
____ Treatment Plan
____ Financial Information
____ Psychiatric Evaluation
____ Medical Assessments, Lab Tests, etc.
____ History of Drug/Alcohol Abuse
____ Other Evaluations/ Assessments (Specify)_____

____ All pertinent information_____
____ Other (Specify) _____

CONDITIONS OF THE RELEASE

This consent becomes effective _____, 20___. This consent may be revoked by the undersigned at any time except to the extent that action has already been taken. If not revoked, it shall automatically terminate at the end of one year from the effective date.

I understand: (1) I may receive a copy of this signed authorization; (2) I may view my case files, except when prohibited by law; (3) this release may result in disclosure of the fact that mental health, drug or alcohol service have been/ are being provided; (4) federal rules do restrict any use of the disclosed drug or alcohol information to criminally investigate or prosecute me or the individual named on this release.

Signature _____Date:_____

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