

MOTIVATIONS COUNSELING PLLC AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name _____ **Date of Birth** _____

Parent/Guardian Name _____

(if client under 18 years old)

I authorize _____ to disclose to and/or obtain
from _____ the following information:

Description of Information to be Disclosed

(Client should initial each item to be disclosed.)

- | | |
|---|---|
| <input type="checkbox"/> Diagnostic Assessment
<input type="checkbox"/> Psychological Evaluation
<input type="checkbox"/> Psychiatric Evaluation
<input type="checkbox"/> Treatment Plan/Recommendations
<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Treatment Update/Summary | <input type="checkbox"/> Diagnosis
<input type="checkbox"/> Attendance at Sessions
<input type="checkbox"/> Testing Results
<input type="checkbox"/> Educational Information
<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Other _____ |
|---|---|

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify: _____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to MOTIVATIONS COUNSELING PLLC at the above address. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on _____.

Conditions

I further understand that my MOTIVATIONS COUNSELING PLLC therapist will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Re-disclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances: _____

I will be given a copy of this authorization for my records upon request.

Signature of Client _____
Date

The undersigned attests to having legal authority to act on behalf of minor child/client, and hereby give(s) consent for release of information as stated above.

Signature of Parent, Guardian or Personal Representative _____
Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, etc.). _____

Check here if client/parent/guardian refuses to sign authorization.

Signature of Staff Witness _____
Date