The Works Counseling Center

PROGRESS NOT PERFECTION

AUTHORIZATION TO RELEASE INFORMATION

I, _____, authorize the mutual exchange of information
(client's/parent's name)

between The Works Counseling Center and _____.
(name of person or organization)

Information to be released includes: (check boxes):

☐ Social History
☐ Psychological Reports or Evaluations
☐ Psychiatric History
☐ Entire Record
☐ Legal History
☐ Treatment Goals
☐ Medical History
☐ Other _____
☐ Protected Health Information (if checked, this must be a consent for release of PHI only)

Information is released for the purpose of: (check boxes):

☐ Continuity of Care
☐ Service Planning
☐ Education Planning
☐ Personal Reasons
☐ Assessment
☐ Legal Purposes
☐ Discharge Summary
☐ Other _____

I understand that my records are protected under specific federal and state confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it (e.g. the provision of treatment upon consent to disclosure to third party players) and that in any event this consent expires automatically as described below.

This authorization of exchange of information is valid for one year from date of signature.

I understand that information used of disclosed pursuant to this authorization may be subject to subsequent disclosure by the recipient and no longer be protected by the HIPPA privacy rule.

I further acknowledge that the information to be released was fully explained to me and that this consent is given of my own free will.

Signature: _____

Printed name: _____ Date: _____