Consent to Release Information

I, _____, authorize

(Client Name, [if a minor, also include Parent/Guardian Name])

Lori Zoucha, LMHP, CPC, NCC to __disclose to and _____to receive information from:

_____ Attorney

_____

_____ Probation or Other Government Entity:

_____

Treatment Provider

_____

____ Insurance or Medicaid

_____

_____ Name and Phone Number of One Friend

_____

_____Name and Phone Number of One Relative

_____

INFORMATION and PURPOSE for RELEASE

Authorization is hereby given to exchange information in written, verbal, or electronic form regarding the above named individual between the above listed agencies and individual(s) to be used for the purpose(s) of:

☐ Assessment ☐ Coordination of Services ☐ Continuity of Care ☐ Insurance ☐ Legal ☐ Collateral

The specific information to be exchanged is as follows:

_____ Aftercare/Discharge Plan
_____ Current Medications
_____ Discharge Summary
_____ Drugs/Alcohol Information/Evaluation
_____ Financial Resource and Eligibility
_____ Individual Education Plan
_____ Medical/Social History
_____ Progress Reports/Summary of Treatment
_____ Psychiatric History and Diagnosis
_____ Psychological Testing Information
_____ Treatment/Service Plan
_____ Other: _____

This authorization specifically includes:

☐ Mental Health ☐ Drug/Alcohol ☐ Other:_____

If requested records include drug and alcohol information, I understand that my alcohol and drug treatment records are protected under the federal regulations governing Confidentially of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand this Release of Information may be revoked at any time, except to the extent that action has already been taken and reliance on this Release of Information. I understand if I wish to revoke this Release of Information, I must do so in writing and present my written revocation to Lori Zoucha, LMHP, CPC, NCC.

Unless otherwise revoked, this Release of Information will expire on the following date, event, or condition: _____. (90 days for one time request/180 days for ongoing services). If I fail to specify an expiration date, event, or condition, this Release of Information will expire one hundred eighty (180) days from the date below.

I understand this Release of Information is voluntary. I can refuse to sign this Release of Information. I need not sign this Release of Information in order to receive treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided for in, and subject to the limitations of, 45 C.F.R. §164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may no longer be protected by federal and state confidentiality laws.

By signing this form, I consent to the service provider identified above disclosing my protected health information:

_____ _____
Client Signature Date

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Therapist Signature Date