FAMILY MATTERS COUNSELING AND CONSULTING LLC

RELEASE OF CONFIDENTIAL INFORMATION

Client Name: _____ **Date of Birth:** _____

Address: _____

I authorize Family Matters Counseling and Consulting LLC to disclose to and/or obtain from:

Agency/Individual **Address** **Phone**

_____

The following information:

1. Any and all health and mental health records and information including evaluations of psychiatric, and/or psychological conditions, alcohol & drug use, treatment plans/summaries/recommendations, referral information, progress notes, lab tests, and diagnosis.
2. Medical records including medications prescribed, diagnosis, hospital admission histories, discharged summaries and, laboratory testing results.
3. Work/School records including attendance, performance reports, grades, and behavior reports.
4. Appointment scheduling, attendance, and other information that is directly relevant and necessary.
5. Other:_____

The purpose of this release is for the purpose of counseling and treatment.

I wish to limit disclosure under above category 1-5 as follows:

_____

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Family Matters Counseling and Consulting LLC. 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 Consent expires in 365 days or as otherwise indicated. I further understand that Family Matters Counseling and Consulting LLC will not condition my treatment on whether Mental Health Treatment gives authorization for the requested 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. I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed by the recipient, and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA, and provides additional privacy protections. I will be given a copy of this authorization for my records.

_____

Signature of Client **Date**

_____

Signature of Parent/Guardian **Date**

_____ Check here if patient/client refuses to sign authorization.

Do we have permission to leave a message to call us on the telephone numbers you have given us? Y N