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Family & Adolescent Counseling Services

Restoring Relationships and Hope in Individuals and Families

AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

CLIENT NAME: _____ **DATE OF BIRTH**: _____

This form when completed and signed authorizes the release of protected and/or confidential psychological information from my clinical record to the person or agencies designated. It is understood that this form does not constitute a general release, and that by checking off or specifying information below I am agreeing to an informed release of specific sensitive and confidential information. It is also understood and agreed that Family & Adolescent Counseling Services (FACS) is not responsible for and cannot control further release by the agencies or individuals this information is sent to.

I authorize Family & Adolescent Counseling Services to release and receive the following individually checked items in their entirety or additional information as indicated below:

	Intake summary		Records of Attendance		Billing Records
	Discharge/Treatment Summary		Aftercare Plans		Diagnostic Information
	Treatment Plans		Progress Notes		Treatment Recommendations
	Letters/Updates to referral source or other treating provider		Probation Reports and Summaries		
	Other (specify) – Summary of Evaluation				

For the specific purpose of: Treatment Collaboration. This communication may be released/received by mailing copies, facsimile, by phone, email, or in person and should only be released to:

Individual	
Agency	
Address	
City/State/Zip	
Phone	
Fax	

This consent is subject to revocation at any time except to the extent that FACS or its agents have already taken action in reliance on it. I hereby release FACS and its agents from any liability which may arise as a result of the use of any information contained in the records released. This authorization will expire 365 days from the date signed. I acknowledge that I have read this authorization, fully understand it contents, and have voluntarily signed it on this date. I understand that the information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of the information, viewed by person unknown, and no longer protected by the HIPAA Privacy Rule or by Federal or State law or rules. **A COPY OF THIS RELEASE SHALL BE AS VALID AS THE ORIGINAL**

Name of Client _____ Date _____

Signature of Client _____ Relationship of Client _____

Signature of Parent/Guardian if client is a minor _____

Witness Signature _____

ATTENTION TO AGENCIES AND/OR INDIVIDUALS TO WHOM THIS INFORMATION IS DISCLOSED:
Prohibition on re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by law. Any further disclosure is strictly prohibited unless the participant provides specific written consent for subsequent disclosure of this information. These records may be protected by Federal Regulation (42 CFR, Part 2). Federal rules restrict any use of the information to criminally investigate or prosecute alcohol/drug abuse participants. If you have received this information in error, please contact our office as soon as possible to arrange for the return of the received material. The information you have been sent may be protected from re-disclosure without informed signed consent from the individual or agency to which it pertains. Do not re-disclose this confidential information without signed informed consent or as otherwise allowed by law.