Permission to Release Information

Client Name: ______________________________________Date of Birth: ____________

I, _________________________________authorize the information specified below to be:

☐ Disclosed by Changes Counseling, LLC
☐ Shared between Changes Counseling, LLC and the entity named below
☐ Received only from entity named below

To and/or From: (please write in specific names)

☐ School____
☐ Former or Current Therapist____
☐ Other Health Care Worker____
☐ Mental Health Agency____
☐ Medical Office or Hospital____
☐ Psychiatrist____
☐ Parent: Name____

Disclosure shall be limited to the following specific information contained in my records and/or obtained during the course of my diagnosis and treatment by Changes Counseling, LLC
(Check YES or NO for each item):

	YES	**NO**
Assessment and Diagnostic Summaries	☐	☐
Diagnosis	☐	☐
Treatment Goals and Progress	☐	☐
Verbal Exchange	☐	☐
Medication Review	☐	☐
Discharge Summary	☐	☐
Other: Specify__________________________	☐	☐

- I am aware of the confidential and/or privileged nature of the information being disclosed, and understand the benefits and/or disadvantages of disclosing such information. I hereby release Changes Counseling, LLC and its representatives, from all legal liabilities that may result from the release of this information.
- I acknowledge that I have the right to revoke this authorization at any time, by sending written notification to clinician treating you. I understand that a revocation is not effective if Changes Counseling, LLC has already taken actions in reliance on the authorization.
- I am requesting that this information be disclosed for the purpose(s) of: ***Coordination of Care***
- This authorization shall be in full force and effect until _____________. If no expiration date is provided, this authorization shall expire one hundred eighty (180) days after the date on which I signed below.
- I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by federal and state privacy laws and regulations.
- I understand that Changes Counseling, LLC will not condition my treatment, payment, or enrollment or eligibility for benefits on whether I provide this authorization.

Notice to Recipient: This authorization provides for a release of information about an individual, whose confidentiality is protected by federal and state laws and regulations, including the Health Insurance Portability and Accountability Act of 1996, and state confidentiality laws as well as the Code of Ethics of Professional Counseling. No information disclosed from this authorization may be re-disclosed without the specific written consent of the individual about whom such information pertains.

____
CLIENT/LEGAL REPRESENTATIVE   DATE

____
THERAPIST   DATE