RELEASE OF INFORMATION CONSENT FORM

Client Information

Client's Name: _____ Date of Birth: ___/___/___
Address: _____ City: _____ State: ____ Zip: _____
Home Phone: _____ Work Phone: _____ Ext: _____

Release Information

I, _____ , authorize Clovis Counseling/Valente Orozco, LCSW to

- ☐ Send Information To:
- ☐ Receive Information From:

Name: _____
Address: _____ City: _____ State: ____ Zip: _____

Release Details

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR PSYCHOTHERAPY NOTES

RELEASE TYPE

Release the following types of information:

- ☐ Consultation Reports
- ☐ Behavior Recommendations
- ☐ Progress Reports
- ☐ Attendance in Treatment
- ☐ Clinical Assessment Reports
- ☐ Other (Please Specify):
- ☐ Psychological Testing Results
- ☐ Treatment Plans
- ☐ Services Reports
- ☐ DSM-IV-TR Diagnosis

_____

_____

(PLEASE COMPLETE BACK OF FORM ALSO)

Release Details (CONT.)

RELEASE PURPOSE

The released information will be used for the following purposes:

- ☐ Planning Appropriate Treatment or Program
- ☐ Continuing Appropriate Treatment or Program
- ☐ Determining Eligibility for Benefits or Program
- ☐ Case Review ☐ Updating Files
- ☐ Other (Please Specify):

_____

_____

Release Signatures

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your Relationship to Client: ☐ Self ☐ Parent/Legal Guardian ☐ Legal Representative ☐ Other (Describe):

_____

NOTE: If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: _____ **Date:** ___/___/___

Parent/Guardians/Personal Representative (If Applicable)

Signature: _____ Date: ___/___/___

Witness (If Client is Unable to Sign)

Signature: _____ Date: ___/___/___