**Release of Information**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Kayla McGill, LCPC to send and receive the following information regarding the above identified client:

 Medical history and evaluation(s)

 Mental health evaluations

 Developmental and/or social history

 Educational records

 Progress notes, and treatment or closing summary

 Other

Information will be sent to and received from:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Company or Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My relationship to client:

 Self

 Parent/legal guardian

 Personal representative

 Other

The above 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

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 (some states vary, usually 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.

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.

Release of information is effective \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and will expire \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client name Client Signature (12 years or older)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian Signature Therapist Signature

\_\_\_\_\_\_\_ My initials in this space act as my electronic signature.