

PACIFIC COUNSELING ASSOCIATES

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AUORIZATION FOR RELEASE OF INFORMATION

Client's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ DOB: ____/____/____

I, _____, authorize _____ to: (send)___ (receive) ___ the following: _____

(to) _____ (from) _____

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

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

- Academic testing results, Psychological testing results, Behavior programs, Service plans, Progress reports, Summary reports, Intelligence testing results, Vocational testing results, Medical reports, Entire record, except progress notes, Personality profiles, *Psychotherapy Notes, Psychological reports, Other, specify

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 (specify)

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 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 ___Personal representative ___Other (describe) _____

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/guardian/personal representative (if applicable)

Signature: _____ Date: ____/____/____

Witness (if client is unable to sign)

Signature: _____ Date: ____/____/____