Soper Counseling Group

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

I, _____, hereby authorize the release and disclosure of the following clinical and/or therapeutic records for the following purpose(s):

[ ] Authorization to release information regarding counseling and therapy care and treatment.

[ ] Authorization to release information held under the Drug Office and Treatment Act of 1972 (PL-92255) and the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act Amendments of 1974.

[ ] Authorization to release information related to Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

Please release authorized information between Soper Counseling Group and:

_____ Psychiatrist: _____

_____

_____ Primary Care Physician: _____

_____

_____ School Official: _____

_____

_____ Family Member: _____

_____

_____ Other: _____

_____

_____Specific information to be released (client's initials to approve release):

_____ Assessments and evaluations _____Psychosocial history

_____ Continued care & treatment _____Discharge summary

Correspondence (specify): _____ _____

Other (specify):_____ _____

Purpose(s) for which information is to be released:

_____

_____

_____

_____

_____

_____Revocation/Expiration: This Release of Information is subject to revocation by the under-signed at any time except to the extent that information has already been disclosed based on authorization contained herein. Unless further limited by a date stated here,_____ _____, this Release of Information will automatically expire after a period of 180 days from the date signed. I have the right to receive a copy of this Release of Information upon my request.

Client's Name: _____ Signature: _____ _____ Date: / /

Gaurdian's Name:_____ Signature: _____ _____ Date: / /

Therapist Name:_____ Signature: _____ _____ Date: / /