The Integrative Counseling Center
Physiology Cognition Spirituality

RELEASE OF INFORMATION CONSENT FORM

Client's Name: _____

I authorize _____ to send and receive the following information:

- ❑ Client history and mental health evaluations
- ❑ Medical and psychiatric records
- ❑ Developmental and/or social history
- ❑ Clinical session notes
- ❑ Educational record
- ❑ Treatment summary
- ❑ Other: _____

To / From: _____ **Phone/Fax:** _____

Your relationship to client: ❑ Self ❑ Parent/Legal Guardian ❑ Other:_____

The above information will be used for the following purposes:

- ❑ Treatment planning or case consultation
- ❑ Assessment, evaluation or 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.

Signature: _____ **Date:** _____ **Valid Until:** _____

Witness (if client unable): _____ Date: _____ Valid Until: _____