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Authorization for Release of Information

This form when completed and signed authorizes the release and/or exchange of protected information from your clinical record to the person(s) designated.

I_____authorize Northwinds Counseling Services to release and/or exchange the following types of information:

__ Initial Assessment
__ Case Notes
__ Consultation Reports
__ Chemical dependency Evaluation
_Treatment Plan
_Psychological Testing and Evaluations
_Educational Assessments
_Other (Specify)

I am authorizing the release of this information for the following reasons:

- Background information/Assessment
- Coordination of Care
- Other (specify)

This information will be released and/or exchanged with:
Individual and Clinic Name _____
Address:_____
Phone/Fax: _____

This authorization will expire:

- Immediately after requested information is received
- 30 days after termination of treatment

Other _____

You have the right to revoke this authorization, in writing to Northwinds Counseling, at any time. However, your revocations will not be effective on action already taken in reliance of this authorization or, if this authorization was obtained as a condition of obtaining insurance coverage, to which the insurer has a legal right to consent a claim.

Your therapist may not in general, condition the providing of psychological services upon your signing an authorization, unless the psychological services are being provided to you for the purpose of creating health information for a third party.

The information disclosed pursuant to this authorization may be subjected to redisclosure by the recipient of your information and no longer protected by the HIPPA privacy rule.

If this authorization is signed by a personal representative of the client, a description of such representative's authority to act on behalf of the client must be provided.

Signature of client and/or guardian for client_____Date _____