**Authorization to Release Information**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Monty Shultz Counseling & Neurofeedback**\_\_\_\_\_\_\_\_is authorized to disclose/receive the following regarding \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize **Monty Shultz Counseling and Neurofeedback**

To: \_\_\_\_\_\_ Disclose to

\_\_\_\_\_\_ Obtain from

Organization or individual:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Fax Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Information to be released (check appropriate category)*

\_\_\_ Social History \_\_\_ Medical History \_\_\_ Diagnosis

\_\_\_ Treatment \_\_\_ Educational Records \_\_\_ Test Results

\_\_\_ Psychological Assessment \_\_\_ Neuropsychological testing results \_\_\_ Treatment Plan

\_\_\_ Mental Status Exam \_\_\_ Drug and Alcohol Evaluation \_\_\_ PTA \_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*The purpose of this disclosure is to:*

\_\_\_ Assist with evaluation and treatment \_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I have a right to revoke this authorization at any time. I understand that a revocation will be made in writing and will not apply to information that has already been released in response to this authorization. I understand that a revocation will not apply to my insurance company when the laws provides my insurer with the right to contest a claim under my policy. Unless previously revoked this authorization will automatically expire six (6) months from date of discharge. I consider a photocopy of this authorization to be as valid as the original.

I understand that my records may include related drug and alcohol abuse information which is protected under the Federal Confidentiality Regulations (42 CFR, Part 2). Any further disclosure of my records other than what is outlined above is prohibited without my specific written consent, or otherwise permitted by such regulations.

I further acknowledge that the information being released was fully explained to me and this consent is given willingly.

Executed this\_\_\_\_\_\_\_day of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,20\_\_\_

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

(Signature of Patient/Guardian) (Signature of witness)

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

(Relationship to client)