Family Life Counseling and Psychological Services, LLC

4142 Keaton Crossing Blvd, Suite 101
O'Fallon, MO 63368
636-300-9333 Fax: 636-300-8761

Consent to Release/Obtain information

I, _____ authorize and request Family Life Counseling and Psychological Services to disclose/release or obtain the below specified information of:

Name	Date of Birth	Social Security Number

To or From: (Check or list all that apply)

____ St. Charles County DFS—Caseworker _____
____ St Louis County DFS—Caseworker _____
____ St. Louis City DFS—Caseworker _____
____ School (Please list name, address, phone number and teacher) _____
_____
_____
____ Physician_____
____ Therapist _____
____ Lawyer _____
____ Other _____

The Purpose of this disclosure: _____.
The specific information to be disclosed is (check all that apply)
____ Educational Testing, IEP, transcript, grade reports
____ Behavioral reports
____ Progress Notes
____ Psychological testing
____ Treatment Plan
____ Medical records
____ Other _____

Read Carefully:

1. I understand that my medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of my Medical/Health information. The protected health information (PHI) in my medical records includes mental/behavioral health information. In addition, it may include information relating to sexually transmitted diseases, AIDS, HIV, other communicable diseases, and or alcohol/drug abuse.

2. Alcohol and drug abuse information records are specifically protected by federal regulations and by signing this authorization without restrictions I am allowing the release of any alcohol and/or

drug information records (if any) to the agency or person specified above. Please sign if you are authorizing the release of alcohol and drug abuse information.
Signature:_____

3. This authorization includes both information presently compiled and information to be compiled during the course of treatment at Family Life Counseling and Psychological Services or agency paying for services, during the specified time frame.

4. This Authorization becomes effective on the date signed and will automatically expire in one year.

5. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so **IN WRITING** and present my written revocation to the therapist involved in my case. I further understand that actions already taken based on this authorization, prior to revocation, will not be affected.

6. I understand I have a right to receive a copy of this authorization.

7. A photographic copy of this authorization is as valid as the original

8. I understand that authorizing the disclosure of this medical/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my medical/health information, I can contact the privacy officer for this covered entity.

The following applies to alcohol and/or drug abuse treatment information records: Prohibition of Re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal Law, Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for disclosure of medical or other information is not sufficient for this purpose.

My signature below acknowledges that I have read, understand, and authorize the release of my PHI.

Signature of Client	Date
Signature of Parent/Legal Guardian/Representative	Date
Witness	Date

Notice of Revocation

Date: _____

I, _____ hereby revoke my authorization of this disclosure of information to Family Life Counseling and Psychological Services. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

Signature: _____