

AUTHORIZATION TO RELEASE INFORMATION

Full name of client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby give consent to Be Well Counseling Services, PC

101 West 4th Street Portales, NM 88130 and 3017 N. Prince Clovis, NM 88101

(Address and Zip Code)

To release to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

(Address and Zip Code)

Information from the records of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name of Client)

Information to be released is limited to (check the appropriate information):

\_\_\_Social History \_\_\_Medical History \_\_\_Progress Notes

\_\_\_Diagnosis \_\_\_Treatment Summary \_\_\_Test Results

\_X\_Other \_\_\_Information for insurance claims, and primary care physician communication

The purpose of the disclosure is (check the appropriate purpose):

\_\_\_To assist with this individual’s evaluation and treatment

\_X\_Other \_\_\_Information for insurance claims, and primary care physician communication

I understand that all client information is confidential and my records, with respect to alcohol and drug abuse, are protected under the Federal Confidential Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my expressed revocation, this authorization will automatically expire:

\_\_\_Upon receipt of the requested information;

\_\_\_After six months (60 days for alcohol and drug abuse records) from date of signing;

\_\_\_On \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(date supplied by client); or

\_X\_Under the following conditions: upon completion of counseling\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I may examine the confidential information to be released upon approval of my counselor. If approved, I may obtain photocopies of this information. (charge for photocopying client records is 25 cents a page)

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

Signature of Client

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

Date

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

Witness’ Signature

If client is unable to sign give reason, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of legally authorized representative Relationship to client Date Witness’ Signature