Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby give permission to RECLAIM COUNSELING & WELLNESS to: RELEASE INFORMATION TO: AND/OR OBTAIN INFORMATION FROM (in verbal or written form):

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

(Name of referring doctor, agency, attorney, school counselor, therapist.)

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

Address or Phone number, fax (if known)

INFORMATION TO BE DISCLOSED/OBTAINED:

\_\_ Summary of evaluation and treatment/Previous Mental Health Treatment

\_\_Social/family history

\_\_Medical History and physical exam

\_\_Psychiatric evaluation

\_\_Alcohol and substance abuse information

\_\_Psychological evaluation

\_\_Progress notes

\_\_Ongoing verbal exchange regarding treatment and progress

\_\_School records, grades, test scores, teacher observations

\_\_Diagnosis

\_\_Medication information, medical information

\_\_Treatment summary, discharge summary

\_\_Treatment recommendations

I understand this information will be used for:

\_\_\_\_\_Evaluation and treatment planning

\_\_\_\_\_Referral

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal

Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations. I understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and may contain confidential HIV/AIDS – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named above. Any information on this form that is unclear to me has been explained to my satisfaction by Ashley. I understand the information to be released, the need for information, and that there are statues and regulations protecting confidentiality of the authorized information. I understand this consent is voluntary. It will expire one year from the date of signature noted below. I may revoke this authorization in writing.

Signature of patient, parent, guardian or authorized agent DATE