

Authorization for Release of Information

 Client name Date of Birth Date

I, _____, hereby authorize, Kathryn McClearn MC,LPC at Growth Space Counseling to make disclosure of protected health information including :

(please specify by checking what you allow to be released)

<input type="radio"/> Dates of Services	<input type="radio"/> Progress Notes	<input type="radio"/> Diagnosis/es, Prognosis
<input type="radio"/> Treatment plans and Goals	<input type="radio"/> Summary of Treatment	<input type="radio"/> Recommendations
<input type="radio"/> Substance use/ abuse info. _____ (initial)	<input checked="" type="checkbox"/> Reciprocal Communication	<input type="radio"/> Other

To Person/Agency making request to receive disclosure: (who is your emergency contact?)

Name: _____ Address: _____

Phone: _____ Fax/Email: _____

Records dating, From: N/A----- To: -----

- I do not authorize Kathryn McClearn MC, LPC to disclose any records on drug abuse, alcoholism, sickle cell anemia, human immunodeficiency virus(HIV), acquired immunodeficiency syndrome(AIDS), or genetics testing information. *(check if applies)*

Purpose for disclosure:

_____ Will be contacted in the case of an emergency. _____

I understand and I may revoke this authorization at any time in writing the Kathryn McClearn MC, LPC. The revocation will be effective except to the extent that action based on this authorization has already been taken. Kathryn McClearn MC, LPC may not condition treatment, payment, enrollment or eligibility benefits on whether the client signs the authorization. The information used or disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by federal privacy law.

This consent will expire *(please check one)*:

<input type="radio"/> DATE:	<input type="radio"/> Upon discharge from the provider	<input checked="" type="checkbox"/> 1 year from date of signed release
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 Signature

 Date

 Name *(printed)*

 Name/Relationship to client if completed by guardian

Notice: Alcohol and drug abuse patient records are protected by Federal confidentiality regulations (42CFR part 2). The Federal regulations prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 43 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Communicable disease related information, pursuant to this release, cannot be redisclosed without specific written authorization (A.R.S. 36-664. H))