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)

✓ **Dates of Services**	✓ **Progress Notes**	✓ **Diagnosis/es, Prognosis**
○ **Treatment plans and Goals**	✓ **Summary of Treatment**	✓ **Recommendations**
✓ **Substance use/ abuse info. _____ (initial)**	✓ **Reciprocal Communication**	○ **Other**

To Person/Agency making request to receive disclosure: (Insurance Company info.)

Name:_____ Address:_____

Phone:_____Fax/Email:_____ _____

Records dating, From:_____ 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:

_____

_____

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.

Growth Space Counseling will bill insurance as a courtesy, but if the insurance company does not pay for services after 90 days, the client is ultimately responsible for payment. My signatures below attest to my assignment of benefits where I permit the insurance company to assign Growth Space Counseling LLC.

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

○ DATE:	○ Upon discharge from the provider	✓ 1 year from date of signed release

_____ _____

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 of 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))