



RELEASE OF INFORMATION

Client Name: _____ Social Security Number: _____ DOB/Age _____
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I the undersigned, authorize Associated Counseling Group to:

	<input type="checkbox"/> Receive	<input type="checkbox"/> Obtain	<input type="checkbox"/> Exchange
Agency/Individual _____			Phone: _____
	<input type="checkbox"/> Receive	<input type="checkbox"/> Obtain	<input type="checkbox"/> Exchange
Agency/Individual _____			Phone: _____
	<input type="checkbox"/> Receive	<input type="checkbox"/> Obtain	<input type="checkbox"/> Exchange
Agency/Individual _____			Phone: _____
	<input type="checkbox"/> Receive	<input type="checkbox"/> Obtain	<input type="checkbox"/> Exchange
Agency/Individual _____			Phone: _____

I further authorize the release, exchange or attainment of the following items:

Medical: diagnosis, prognosis, medications, testing, treatment, laboratory, pharmacy and lab reports including (blood levels).

Psychiatric: diagnosis, prognosis, evaluation, medication checks, clinical notes and discharge summary.

Psychological: diagnosis, prognosis, evaluation, testing results-both formal and informal.

Therapeutic: intake, social history, treatment plan, progress notes, staffing notes and discharge summary.

Payment: any medical or other information necessary to process this claim. I also request payment of government payments directly to Associated Counseling Group. I further authorize payment of medical benefits and/or mental health services directly to Associated Counseling Group.

This release is requested for the following purpose(s).

- Referral for services**
- Assistance in assessment and/or treatment planning.**
- Case consultation, coordination, monitoring.**

- 1.) I understand that this consent will remain in active for 60 days following the termination of all my services.
- 2.) I understand that I have the right to choose to inspect the written information that will be released with this authorization and that if chosen such an inspection will occur in a meeting with Associated Counseling Group staff.
- 3.) I understand that I may revoke this consent at any time by providing a written revocation to Associated Counseling Group
- 4.) I understand that any release of information which has been made prior to revocation of the release and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality.
- 5.) I understand that either a photocopy or a facsimile of this authorization to relapse information shall be deemed as valid and effective as the original.

Parent of Guardian Signature Date

Client Signature Date