Consent for Release of Confidential Information

Client Name: _____ DOB: _____

By signing below, I give my permission to Beth Miller, LCSW to release and/or receive my/my child's confidential information to/from:

Name of Facility/ Person: _____

Address: _____

_____

Phone #: _____

I authorize the release of the information listed below, which requires specific consent under law. (you must initial all that apply).

____ Mental Health _____ Substance Abuse

____ HIV/AIDS Related

I authorize the following information to be released, shared and exchanged. (you must initial all that apply).

____ Diagnostic Evaluation/Intake

____ Progress Notes

____ Discharge Information

____ Other, specify: _____

The purpose of the release of this information is for:

____ Continuation of Care _____ Insurance

____ Attorney/Legal _____ School

____ Disability/Eligibility _____ Personal Reasons

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Please initial each of the following statements and sign at the bottom.

_____ *I understand that my information may not be protected from re-disclosure by the requester/recipient of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations (CFR 42, part 2), and the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 CFR, part 160 & 164, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.*

_____ *I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment for services.*

_____ *I understand that if I fail to specify an expiration date or condition this authorization is valid for a period of one year from the signature date. I also understand that I may revoke this authorization at any time. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.*

I have read the above agreement and I consent to release of information as outlined above.

_____	_____	_____
Signature of Client	Date Signed	Expiration Date
_____	_____	_____
Signature of Legal Representative	Date Signed	Expiration Date

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Complete the following ONLY if you wish to revoke the authorization:

_____, am revoking this consent to release information,

effective ____/ ____/ _____.