PERMISSION TO RELEASE RECORDS

In order to comply with your release request, please fill out this form completely. Much of the information is REQUIRED by federal and state law. Clients/representatives may be charged a fee for copies of records. **PLEASE PRINT**

Client Name: _____Date of birth: _____

Current Address: _____

Phone: _____ Last four digits of SS# _____

Purpose of Release:
Changing Counselors___ Legal Reasons___ Self Use___ Other _____

Type of information to be released:
__ Appointments __ Counselor Progress Notes __Assessment __ Test Results

__Other (please specify) _____

PLEASE INDICATE FORM OF RELEASE Fax___ Mail___ Pick up___
Must have Fax numbers and Mailing addresses to process requests.

I _____ authorize The Counseling Center to RELEASE / RECIEVE information TO/ FROM:

Name: _____ Phone: _____

Address: _____ Fax: _____

_____

This authorization is valid for 90 days from date signed unless authorization has been revoked by client orally or in writing. If signing for a person under 18 years of age, you are stating you are the legal guardian.
The release of this information does not include HIV/AIDS related information. A separate release is required to share that information.

I understand that alcohol, drug, and mental health treatment are protected under Federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records (42 CRF Part 2) and Health Insurance Portability and Accountability Act (HIPPA) of 1996 (45 CRF Parts 160 & 164), and cannot be disclosed by the program or re-disclosed by those receiving this information without my written consent, or as otherwise permitted by these regulations.

Signature of client or legal guardian (state relationship) **Date**

_____ _____

The Counseling Center
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