Release of Information
Patrick Ewing, Licensed Psychologist

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Client Name:_____ Birth Date: _____ Soc. Sec #: _____

I understand by signing this form, I am allowing Counseling Associates to disclose to and/or obtain information concerning the above named client to:

_____
Name of Person and/or Institution

_____
Complete Mailing Address/Street/P.O. Box City/State/Zip Code

Description of Information to be Disclosed

____Assessment	____Testing Information	____Medication List
____Diagnosis	____Educational Information	____Billing Information
____Psychosocial Evaluation	____Presence/Participation in Treatment	
____Psychological Evaluation	____Continuing Care Plan	
____Treatment Plan or Summary	____Progress in Treatment	____Other _____

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify:

_____

This authorization is voluntary and I may cancel this consent to release information at any time by sending written notice to Counseling Associates at the address above. I understand that any release which was made prior to my cancellation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized redisclosure and once information is disclosed it may no longer be protected by federal privacy regulations. . I understand that I may review the disclosed information or ask questions by contacting Counseling Associates at the above address.

I further understand that Counseling Associates, Inc. may not require this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in denial of those services.

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances:

This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated (specify number of days/months:_____

_____ _____
Signature of Client, Parent, Guardian or Personal Representative Date

_____
Relationship if not the client

_____ _____
Signature of Staff Witness Date

Specific Authorization for Release of Information Protected by State or Federal Law

I specifically authorize the release of data and information relating to the following (check appropriate box(s)

☐Substance Abuse ☐ Mental Health ☐ HIV Related Information

IN ORDER FOR THIS SPECIFIC INFORMATION TO BE RELEASED, YOU MUST SIGN HERE AND ABOVE

_____ _____
Signature of Client, Parent, Guardian or Personal Representative Date

Revised 11/16/10