# RELEASE OF INFORMATION AUTHORIZATION

I,_____, ☐ client, ☐ parent, ☐ legal guardian, authorize

## PREFERRED COUNSELING

RELEASE THE FOLLOWING INFORMATION:

☐ Intake Assessment
☐ Treatment Plan/Discharge Summary
☐ Psychiatric Assessment/Notes
☐ Psychological Testing
☐ Summary of Treatment
☐ Observations/Recommendations
☐ Diagnostic Impressions
☐ Record of Attendance
☐ Other:_____

FOR THE RECORDS OF: _____ born on _____ social security #_____

RELEASE TO/ REQUEST FROM:_____.

FOR THE PURPOSE OF:

☐ Coordination of Services
☐ Complying with Court Order
☐ Program Planning
☐ Treatment Planning
☐ Insurance Certification / Authorization
☐ Other:_____

ALLOWABLE FORM OF RELEASE:

☐ Written ☐ Electronic ☐ Video
☐ Audio ☐ Verbal ☐ Other:_____

I, the undersigned, understand that this authorization expires six months from the date signed unless otherwise specified (Specified Date/Event) Consent Expires (Circle One): UPON DISCHARGE or DATE: _____ I also understand that I may revoke this consent (in writing) at any time prior to the actual release of the above specified information. I know I may refuse to sign, and that treatment will not be conditioned on my authorization unless medically necessary. I have not the right to inspect or copy the information to be disclosed and/or any authorizations. I understand I am authorizing the release of any information contained in my records pertaining to the diagnosis and treatment of HIV and AIDS and any information pertaining to the diagnosis and treatment of alcohol/chemical use, abuse, or dependency. I also understand that the receiving agency/person may not be required to protect the confidentiality of the information. A fee may be charged for copying/releasing medical records.

_____ Signature of client or legal representative

_____ Witness Signature

_____ If signed by legal representative – relation to client

_____ Date

TO THE PARTY RECEIVING THIS INFORMATION:
*This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR, Part 2) prohibit you from making any further disclosure of or without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. It is the exclusive responsibility of Preferred Counseling Staff to disclose this information to the consumer.*

RETURN REQUESTED INFORMATION TO:
☐ Preferred Counseling
P. O. Box 3
Fort Smith, AR 72903

ATTENTION:
☐ Cheryl Edwards, MS, LPC
☐ Ben Storie, MA, LPC, LADAC
☐ Paul Rust, LCSW, LMFT
☐ Carrie Feero, LPC, LMFT
☐ Christa Means, LPC, LMFT