Jeanne L. Meyer, LMHC, LPC, MAC
6108 NE Hwy 99, Suite 102
Vancouver, WA. 98665

Phone: (360) 949-2524
e-mail: Jeanne@ChoicesCounseling.org

AUTHORIZATION TO RELEASE INFORMATION

Client:____________________________________ DOB:______________

1. *AUTHORIZATION FOR RELEASE.*

I hereby authorize

CHOICES COUNSELING
Jeanne L. Meyer, LMHC, LPC, MAC
6108 NE Hwy 99, Suite 102
Vancouver, WA. 98665

to release, disclose, and deliver the information described below to:

(Name)____of

(Company)____

(Address)____

(Phone/Fax/Email)____

2. *SPECIFIC AUTHORIZATION. Initial items you authorize be discussed or released.*

____ Assessment results, including client history, Mental Health Diagnosis, Treatment Recommendations

____ Medication Management Information

____ HIV/AIDS related records (Except HIV test results)

____ Therapy information including presence in therapy, appointment times & dates, attendance, progress in treatment, therapeutic techniques employed

____ Presence in therapy, Appointment times, length and dates, MH diagnosis, Treatment Recommendations

____ Substance Abuse information including history, diagnosis, treatment
Substance Abuse information is limited to the following: _______________________________.
For the following time period____.

____ Other Information____.
This authorization includes reports, correspondence, test results, and any other information in the records generated by the authorized provider. I do not give permission for any other use or redisclosure of the information.

3. PURPOSE: Initial the specific reasons you agree that I discuss/release information

______ Involve individual(s) in treatment

______ Consultation & Coordination of Tx Services

______ Notify of emergency situation, coordinate care and referral

______ Assist in scheduling appointments or leaving messages

______ Bill for Services

_______Other ______________________________________

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4. *REDISCLOSURE.*

This release does not authorize redisclosure of information beyond the limits of this consent. The Recipient of this information is prohibited from using the information for any purpose other that that already stated and from disclosing it to any other party without further authorization. The following written statement should accompany certain disclosures:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

I specifically understand and agree that the redisclosure requirements set out above will apply to these records.

5. *VALIDITY.*

This authorization, unless otherwise indicated, becomes effective on the date signed and may be revoked by me at any time, except to the extent action that has already been taken. If not earlier revoked, this authorization shall terminate automatically within one year of the date of execution unless otherwise specified. I understand that the information authorized by this release will be provided to the authorized recipient(s) only. Additional information may be provided to those recipients only with signed consent from me. I further understand that I have a right to receive a copy of this authorization and any information released upon my request.

6. *NOTIFICATION OF INFORMATION RELEASED.*

Unless it is not possible due to absence, illness or infirmity I will be notified of any information released, whether in written or verbal form.

I AUTHORIZE THE RELEASE OF INFORMATION AS INDICATED ABOVE.

Client Signature:____Date:______________________

Client Signature:____Date:______________________

Signature of Legal Guardian if client is a minor:_____________________Date:______________________

Counselor Signature: ____Date:______________________

This Authorization to the Release of Information will expire one year from the date signed or on the following:

____