



AUTHORIZATION TO DISCLOSE INFORMATION: GENERAL RELEASE

6400 Thornberry Ct, Suite 620 • Mason, OH 45040

Ph: 513-229-8386 Fx: 513-229-8385

Client Name (First, MI, Last)		Date of Request
Home Phone ()	Work Phone ()	Date of Birth (MM/DD/YYYY)

The following programs/individuals are authorized to exchange information as noted below:			
I, _____, authorize:		Samantha Rowe MS, LPC	
<input type="checkbox"/> to send to	Name (Authorized Individual/Organization to Whom Disclosure is Made)	Phone Number	
<input type="checkbox"/> to receive from			
Address		City	State Zip Code

Purpose of Disclosure:			
<input type="checkbox"/> Coordination of Treatment	<input type="checkbox"/> Gathering information for ongoing treatment	<input type="checkbox"/> Gathering information for treatment planning	<input type="checkbox"/> Other:

Type of Information to be Disclosed:					
<input type="checkbox"/> Presence in treatment	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Assessment information	<input type="checkbox"/> Attendance/treatment dates	<input type="checkbox"/> Information regarding mental health	<input type="checkbox"/> Information from individual and/or family sessions
<input type="checkbox"/> Recommendations	<input type="checkbox"/> Progress in treatment	<input type="checkbox"/> Billing/insurance information	<input type="checkbox"/> Other:		
<input type="checkbox"/> Discharge summary	<input type="checkbox"/> Diagnosis				
<input type="checkbox"/> Treatment plans	<input type="checkbox"/> Billing/insurance information				
<input type="checkbox"/> Urine testing	<input type="checkbox"/> Other:				

Amount of Information to be Disclosed:	
<input type="checkbox"/> Information from any/all admissions to:	<input type="checkbox"/> Other:

This Authorization Expires:	
<input type="checkbox"/> Upon case closure	<input type="checkbox"/> Other (specify date/time/event):

Client Signature or Parent/Guardian/Personal Representative Signature (if applicable)	Date
Counselor Signature / Credentials	Date

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse patient records, 42C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I might be denied services if I refuse to consent to a disclosure for treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

Revocation: This authorization is subject to revocation at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it. This consent may be revoked verbally or in writing.		
I hereby revoke consent in writing:	Client Signature	Date & Time
Authorization verbally revoked:	Counselor Signature	Date & Time

Notice on Prohibition of Re-disclosure: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) and certain state laws. The Federal rules and the state laws 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 CFE, 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 patient.