A · C · F
ADULT CHILD FAMILY
COUNSELING OF MASON

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:**	**Jacob Oedy BA, CT** **ACF Counseling of Mason Ohio**

☐ **to send to** ☐ **to receive from**	**Name** (Authorized Individual/Organization to Whom Disclosure is Made)	**Phone Number**	
Address	**City**	**State**	**Zip Code**

Purpose of Disclosure:

- ☐ Coordination of Treatment
- ☐ Gathering information for ongoing treatment
- ☐ Gathering information for treatment planning
- ☐ Other:

Type of Information to be Disclosed:

- ☐ Presence in treatment
- ☐ Recommendations
- ☐ Discharge summary
- ☐ Treatment plans
- ☐ Urine testing
- ☐ Progress Notes
- ☐ Progress in treatment
- ☐ Diagnosis
- ☐ Billing/insurance information
- ☐ Other:
- ☐ Assessment information
- ☐ Attendance/treatment dates
- ☐ Information regarding mental health
- ☐ Information from individual and/or family sessions

Amount of Information to be Disclosed:

- ☐ Information from any/all admissions to:
- ☐ Other:

This Authorization Expires:

- ☐ Upon case closure
- ☐ 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.