Release of Information

I have been given Compass Counseling Center’s client information materials and policies, which explain the concepts and process of therapy as well as other information pertinent to me as a new client with Compass Counseling Center. I have had an opportunity to read the client information materials and to ask any questions I might have, including:

**Authorization for Use or Disclosure of Protected Health and Other Information**

|  |  |
| --- | --- |
| **Client Name:** |  |
| **Address:** |  |
| **City:** |  | **State:** |  | **ZIP Code** |  |
| **Home Phone:** |  | **Cell Phone:** |  |
| **Date of Birth:** |  | **SSN:** |  |

**Important information regarding this Authorization:**

1. I understand that this Authorization will expire one year after the date of my signature.
2. I agree by signing this Authorization that a photocopy of this Authorization form will be considered as valid as the original.
3. I understand that I may inspect or obtain a copy of the material to be released.
4. I understand that Compass Counseling Center may not release third party information it has not generated itself.
5. I understand that once Compass Counseling Center has released material to either me or a third party at my request, Compass Counseling Center is not responsible for the use made of this information.
6. I understand that I have the right to refuse to sign this release and that neither my present nor future care nor any potential payment for that care will be affected by that refusal except where disclosure of the information is necessary for care.
7. I understand that this consent for use or disclosure of my information extends to the materials specified below that are contained in my service record after my consent is given but before that consent expires.
8. I understand that my service record is protected under Federal and State regulations and the information to be released by my signature may contain information pertaining to medical, psychiatric, substance abuse treatment and/or confidential HIV/AIDS related information (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal Laws and 42 CFR Part 2 for Federal Regulations.).
9. I understand that I may revoke this Authorization at any time, and that any revocation is effective on the date written notification is received but is not retroactive to the data already released in reliance upon this authorization. I understand that in order to revoke this Authorization, I must make a request in writing to the therapist.
10. I understand that I will receive a copy of this form after I sign it.

**I hereby authorized Compass Counseling Center to obtain information from, release information to, and/or exchange information with:**

|  |  |
| --- | --- |
| **Name of Individual and/or Agency:** |  |
| **Street Address:** |  |
| **City:** |  | **State:** |  | **ZIP Code:** |  |
| **Telephone Number:** |  | **FAX Number:** |  |

**Information to be released (Check all that apply):**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Psychiatric Records** |  | **Medical/Dental records** |  | **DSS Records** |  | **CM Records** |
|  | **Psychological Testing** |  | **Educational Records** |  | **Legal Records** |  | **Mental Health record** |
|  | **CSS Service Records** |  | **Emergency Information** |  | **Other (Specify):** |  |

**By signing below, I acknowledge that I have read and understand this Authorization.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client Signature Date of Authorization Date of Expiration**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Legal Guardian/Authorized Representative Date Relationship to Client**