Consent to Release/Obtain/Share Information

Community Counseling Services

Rev 01/17

FILE ☐ SEND ☐ *Make copy and file in chart*

Case Name ___________________________

Case Id# ___________________________

Date ___________

Identifying Information: Sex: _____ Date of Birth ____/______/_______ Last 4 of Social Security#: ______

I hereby give my consent/permission for Community Counseling Services
(Agency Name and Address)

☐ To release information to: ____
(Agency/Person Name Title and Address)

☐ To obtain information from: ____
(Agency/Person Name Title and Address)

For the specific purpose of: ☐ Treatment ☐ Coordination of Services

☐ Other: ____

The extent and nature of the information to be disclosed/obtained must be indicated (*check all that apply*):

- ☐ Evaluations
- ☐ Progress Notes
- ☐ Substance Abuse Records
- ☐ Contact Summaries
- ☐ Identifying Information
- ☐ Other: ____
- ☐ Diagnosis/Prognosis/Recommendations
- ☐ Psychiatric Records
- ☐ Admission/ Discharge Summary
- ☐ Activity Support Plan
- ☐ Individual Service Plan/Plan of Service & Supports

For request and/or release of Medical Records only, Dates of service for which the information/record is requesting or will be release: From Date: _____________________ To Date: ______________

I understand that I may revoke this consent at any time except to the extent that action has been taken. I further understand that this consent **will expire upon** ____
(Specific Date/Event/Condition -Not to exceed 12 months)
and cannot be renewed without my consent. I understand that to revoke this authorization, Individual or Legal Representative must provide a written request and the revocation will not apply to action or information that has already been released/ obtained in response to this authorization. Any information obtained as a result of this release is confidential. State and federal laws and regulations prohibit any entity receiving confidential information from redistributing the information to any other entity without the specific written consent of the person to whom it pertains or as otherwise permitted by law and regulations. I understand the information I authorize for release may include information related to history/ diagnosis and/or treatment of HIV, AIDS, communicable or sexually transmitted disease, and alcohol/drug abuse or dependency.

I understand that confidential information may be released without my consent when necessary for continued services/treatment; when release is necessary for determination of eligibility for benefits, compliance with statutory reporting requirements, or other lawful purpose; if you communicate to the treating physician, psychologist, master social worker or licensed professional counselor an actual threat of physical violence against a clearly identified or reasonably identifiable potential victim or victims; in compliance with reporting requirements under state law of incidents of suspected child abuse or neglect or by court order.

By signing below, I acknowledge receipt of a copy of the signed authorization

______________________	____________	______________________	____________
Individual Receiving Services	Date	Legal Representative *If applicable*	Date
Witness/Credentials	Date		