Consent for Release of Information

Client Information	Name _____ Date of Birth _____ Address _____ City _____ State _____ Zip Code _____ Phone Number_____
Clinic/Health Care Provider Who has the information to be released?	Name _____ Address _____ City _____ State ____ Zip Code _____ Phone Number_____ Fax Number _____
Receiving Party Who will the information be released to?	Name _____ Relationship to Client_____ Address _____ City _____ State _____ Zip Code _____ Phone Number_____ Fax Number _____
Information to Be Released What will be released?	□Whether the client is in treatment or not □Prognosis (diagnosis, opinion of how treatment will benefit client, general peculiarities of case) □Nature of the project (Services offered, purpose and philosophy of program) □Brief statement regarding progress (client's denial, client's understanding of their condition and the disease concept, progress or lack of progress on goals, cooperation with treatment plan and rules) □Brief statement regarding relapse and frequency of relapse (cannot identify specific drugs)
Purpose of Release Why is information being released?	□Referral to other services □Coordination of care □Consultation with Doctor □Consultation with other mental health provider □Transfer of care □Other _____

Signature of Client _____ Date_____

Signature of Provider _____ Date_____

This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____. This authorization may be canceled in writing at any time. A photocopy/fax of this authorization will be treated in the same way as an original. Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

I understand that I may refuse to sign this authorization and that refusal to sign will not affect treatment.

I understand that if I have any questions about my clinical records, or the content within, I can contact Thrive Counseling and someone will meet with me to discuss my records.

I understand that my treatment records are protected under the Health Insurance Portability and Accountability Act of 1996 ('HIPAA'), 45 CFR, Parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time and that that any notice to revoke consent must be in writing.