Live Well Services, Inc. Authorization for Disclosure of Information

_____

Last Name First Name Middle Initial Date of Birth

_____

Address

_____

Telephone

I, _____,
hereby authorize the release and disclosure of the following clinical and/or therapeutic records for the following purpose(s):

[ ] Authorization to release information regarding counseling and therapy care and treatment.

[ ] Authorization to release information held under the Drug Office and Treatment Act of 1972 (PL-92255) and the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act Amendments of 1974. I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

[ ] Authorization to release information related to Suicide Risk/Harm and/or Homicidal Risk/Harm to self or others.

Release to:

Name of Provider/Person: _____

Address: _____

Phone: _____

Specific information to be released (client's initials to approve release):

_____ Assessments and evaluations (specify:) _____ Psychosocial history

_____ Entire mental health record _____ Discharge summary

_____ Summary of treatment

Correspondence (specify): _____

Other (specify): _____

_____

Purpose(s) for which information is to be released (check all that apply):

_____ continuity of care _____ referral

_____ consultation _____ personal

_____ other (please describe): _____

I do not authorize the release of the following information:

_____

Revocation/Expiration: I understand that I may revoke this authorization in writing at any time, except for actions that have already been taken prior to this request. (Forms are available from the therapist.) This authorization will expire ____ days after the signature below. This agency is hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.

Client/Guardian's Name: _____ Signature: _____ Date: ____/____/____

Witness Name: _____ Signature: _____ Date: ____/____/____

Live Well Services, Inc.

Consent to Release Information

I _____, hereby authorize
_____ Of Live Well Services, Inc.
To release/ exchange information to _____

Information to be included: (Check appropriate box(s))

- o Whether the client is or is not in treatment
- o Client's prognosis
- o The nature of the project
- o A brief description of the client's progress
- o A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse

This information is confidential as required by law and agency practice for the purpose of _____

This consent is subject to revocation at any time, except to the extent that the person/program, which is to make the disclosure has already acted upon it. If not previously revoked, this consent will expire 6 months from my date of discharge or on the following indicated date_____

I have been offered and

O Accepted
O Refused a copy of this form

_____ _____
Client's Signature (or person authorized to sign in lieu of client) Date

_____ _____
Therapist's Signature Date