EVOLVE COUNSELING, LLC

AUTHORIZATION to RELEASE/REQUEST INFORMATION

_____

Client Name Date of Birth

_____

Address, City, State, Zip Code Phone

I, _____, authorize **Kelly Coté at Evolve Counseling, LLC** to both obtain and share information with the following organization, persons, agencies, hospitals:

Name:

_____

Address:

_____

Phone: _____ Fax:_____

Purpose for which this information is to be released:

☒ Assessment ☒ Service Planning ☒ Continuity of Care ☒ Other:_____

I authorize the following information to be released:

☒ Diagnosis	☒ Assessment/Opening Summary	☒ Discharge Summary
☒ Psychological Testing/Consultations	☒ Medical Information including History	☒ Medication, Prescriptions, Diagnosis
☒ Drug/Alcohol History and Treatment	☒ Status of Attendance	☒ Treatment Summary and Recommendations
☒ Progress-to-Date Forms	☒ Service Plans	☒ Court Reports/Investigative Reports
☒ Progress in Therapy	☒ Social History	☒ Other: _____

- I understand that the information being requested or released may include evaluation, diagnosis or treatment information regarding the following conditions: mental illness, alcohol or drug abuse, and HIV/AIDS.
- If the information to be released/authorized pertains to the diagnosis and treatment of alcoholism and drug abuse, I understand that the confidentiality of the information is protected by Federal Law 42, C.F.R, Part 2.
- I understand that there is a potential for information disclosed, as a result of this release/authorization, to be redisclosed by the recipient and therefore am no longer protected by the HIPAA Privacy Regulation. I also herewith release **Kelly Coté, LPC, LAC with Evolve Counseling, LLC** from all liability for releasing such information.
- I understand that I may revoke this release/authorization at any time by giving written notice to Evolve Counseling, LLC, except to the extent that action has already been taken to comply with it. Without such revocation, this release authorization will expire on _____/_____/_____ date, or if left blank, one year prior to Nov., 1, 2013 and two years thereafter, from the date of my signature.
- I understand that I am entitled to a copy of the signed form.

_____

Signature of Client Date

_____

Signature of Guardian (if under the age of 15) Date

NOTICE TO WHOM THIS INFORMATION IS GIVEN: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Law prohibits you from making further disclosure of this information without the specific written consent of the person to whom it pertains. If applicable, a minimum necessary determination has been applied to this release/authorization. <u>A Copy of this Release or Authorization is as valid as the original.</u>

I hereby revoke this Authorization to Release/Request Information:

_____

Signature of Client Date

_____

Witness Date