Collaborative Counseling

Phone: 763-210-9966 **Fax**: 763-210-6886

Authorization Form To Release Confidential Information

This form is to be completed and signed by the client or the client's parent/guardian, if client is a minor. A signed form authorizes the release of requested information from your clinical records to an individual or facility.

Client Name: _____DOB: _____

Parent/Guardian Name, if client is a minor: _____

Authorizes Collaborative Counseling, LLC and Therapist: _____

_____ Disclose Information To _____ Obtain Information From _____ Exchange Information With

Name and/or Facility: _____

Address: _____

Phone: _____ Fax: _____

Information Authorized to be released:

_____ Psychotherapy Records	_____ Psychological Evaluation Results	_____ Court Records
_____ Medical Records	_____ Academic Records	_____ Drug or Alcohol Use
_____ All of the above	_____ HIV Status	_____Other: _____

Dates Authorized to Release from: _____ (mm/dd/yyyy) **to** _____ (mm/dd/yyyy)

The authorized information is to be released for the purpose of:

_____ Treatment coordination _____ Patient Access _____ Litigation Other:_____

This authorization expires (ends) on the following date, event or condition: _____

_____

(If a date, event or condition is not specified, this authorization expires 12 months from the date I sign this form).

I understand that: I have the right to revoke this authorization at any time by notifying, in writing, the facility listed above. Revoking this authorization does not apply to information that has already been released under this authorization. I understand I have the right to inspect or copy the health information to be disclosed. Federal privacy laws will protect information going to a health care provider or health plan, covered by federal privacy laws. Collaborative Counseling, LLC cannot re-disclose any information from other persons or entities as protected by state or federal privacy laws. I do not have to sign this form. Treatment will still be provided to me if I do not sign this form. Payment for services is not contingent upon me signing this form, unless those services are for the sole purpose of creating personal information for a third party, such as insurance companies. ***A fee may be charged for retrieval and copying of records according to Federal Rule 164.521.***

_____ _____

Client or Parent/Guardian Signature Date