Xenia Counseling

Release of Information Consent Form

**Indicates a requiredfield*

*Client's Name:_____

*I authorize Xenia Counseling to:
(check all that apply)

___ Send Info
___ Receive Info

*The following information:
(check all that apply

___ Medical History and Evaluation(s)
___ Mental Health Evaluations
___ Developmental and/or Social History
___ Educational Records
___ Progress Notes, Treatment Plans, or Closing Summary
___ Other: _____

*From the following Individual/Company/ Organization *(name of person/place therapist is requesting information from):*

_____

*Phone:_____ *Email:_____

*Your (person completing this form) relationship to client:

___Parent/Legal Guardian
___Personal Representative
___Self
___Other:_____

*Iunderstand that this information may be protected by Title 45 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 & 164) and Title 42 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a healthcare provider covered by state or federal rules. I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have the right to refuse to sign this authorization. If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

_____ _____

Signature Date Witness Signature Date