FAMILY COUNSELING Associates
Christ centered professional counseling

CONSENT FOR RELEASE OF INFORMATION

I, _____ _____
(Name) (Date of Birth)

Address _____
(Street Address) (City, State, Zip)

hereby authorize the disclosure of mental health, general health, educational or alcohol and drug information about me as described below:

[1] ***BETWEEN*** **Family Counseling Associates, Inc.**, 7526 East 82nd Street, Indianapolis, IN 46256, ***and:***

Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

[2] Specific description of the information to be used or disclosed:

- ❑ Diagnosis
- ❑ Medication
- ❑ Recommendations
- ❑ Number of kept/unkept appts.
- ❑ Progress and treatment
- ❑ Lab results/drug screen
- ❑ Psychiatric Evaluation
- ❑ Results of Psychological Testing
- ❑ Social History
- ❑ Classroom behavioral records/Educational Assessment
- ❑ Reasons for treatment
- ❑ Other (specify)_____

[3] The information may be used or disclosed for each of the following purposes:

- ❑ Compliance with court order
- ❑ Collaboration with school
- ❑ Treatment of client
- ❑ Confirmation of referral
- ❑ Court testimony
- ❑ At the request of the Client
- ❑ Other (specify) _____
- ❑ These documents may be faxed.

Note: This form should not be used for FCA to disclose information to a health care provider for treatment, or for FCA payment purposes.

[4] I understand that the information used or disclosed may be subject to redisclosure by the person(s) or class of person(s) receiving it and no longer protected by the Federal privacy regulations.

[5] I understand that I may revoke this authorization by notifying FCA in writing, at the address below, of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any affect on actions already taken by FCA in reliance on this authorization.

[6] I understand that I may refuse to sign this authorization. My refusal to sign ❑ will not ❑ may affect my ability to obtain treatment. (FCA may refuse to provide treatment only in circumstances where FCA provided care to you solely for the purpose of creating protected health information for disclosure to a third party.)

[7] I understand that this information may include information relating to:
- Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV)
- Treatment for drug or alcohol abuse
- Mental or behavioral health or psychiatric care.

[8] **I understand this authorization will expire in 180 days or for as long as I receive FCA services, whichever occurs last.**

Client Initials _____

This form must be fully completed before signing.

_____ _____
Signature of Client (or Personal Representative) **Date of Client** (or Personal Representative) **Signature**

_____
Printed Name of Client (or Personal Representative)

Description of Representative's Authority to Act for Client *(if applicable)*:
❑ Parent ❑ Guardian ❑ Other (describe) _____

_____ _____
Signature of Witness **Date of Witness Signature**

When sending information to Family Counseling Associates (FCA), send to the attention of _____
at 7526 East 82nd Street, Indianapolis, IN 46256 • Phone (317) 585-1060 • Fax (317) 585-9811 • www.FCAHelp.com