CONSENT FOR RELEASE OF INFORMATION

Primary Patient Name ___________________________________ **Date of Birth (MM/DD/YYYY)** ______________

Name of Patient's Legal Representative (if applicable): ____

Relationship to Patient: ___ Parent ___ Guardian ___ Other: ______________________________

Address: ___________________________________ **City:** ___________________ **State:** ____ **Zip Code:** _______

Email address: _______________________________________ **Phone Number:** _____________________________

I, ____ ***hereby authorize the disclosure of mental health, general health, educational or alcohol and drug information as described below,***

between **Family Counseling Associates (FCA) AND:**

Name/Organization: ____ **Phone Number:** _______________

Address: ___________________________________ City:____________________ State: ____ Zip Code: ________

Specific description of the information to be used or disclosed (select all that apply):

- ❑ Reasons for treatment
- ❑ Testing Results
- ❑ Biopsychosocial History
- ❑ Educational Records
- ❑ Diagnosis
- ❑ Medications
- ❑ Psychiatric Evaluation
- ❑ Appointment History
- ❑ Treatment and progress
- ❑ Lab Results
- ❑ Recommendations
- ❑ Other: ___________

The information may be used or disclosed for each of the following purposes (select all that apply):

- ❑ At the patient's request
- ❑ Compliance with court order
- ❑ Confirmation of referral
- ❑ Other: __________
- ❑ Treatment of patient
- ❑ Court testimony
- ❑ Collaboration with school

When sending information to FCA, send to the attention of (FCA Provider/Staff name): _______________________

- I understand that the information used or disclosed may be subject to redisclosure by the person(s) or class or person(s) receiving it and no longer protected by the federal privacy regulations.
- I understand that I may revoke this authorization by notifying Family Counseling Associates (FCA) in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions already taken by Family Counseling Associates in reliance on this authorization.
- I understand that I may refuse to sign this authorization. My refusal to sign may affect my ability to obtain treatment. (Family Counseling Associates may refuse to provide treatment only in circumstances where Family Counseling Associates provided care to you solely for the purpose of creating protected health information for disclosure to a third party).
- 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
- I understand this authorization will expire in 180 days or for as long as I receive services from FCA, whichever occurs last. **Initials:** _____

Signature of Primary Patient (or Legal Representative): _________________________________ **Date** ___________

Signature of Witness: ____ **Date** ___________

Family Counseling Associates

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