

AUTHORIZATION TO RELEASE INFORMATION

I, _____ (insert name of client), whose Date of Birth is _____
_____ authorize HRS Counseling Services, LLC to disclose to and/or
obtain from:

The following information is to be released:

- | | |
|---|--|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Diagnosis |
| <input type="checkbox"/> Psychosocial Evaluation | <input type="checkbox"/> Treatment Plan |
| <input type="checkbox"/> Current Treatment Update | <input type="checkbox"/> Presence/Participating in Treatment |
| <input type="checkbox"/> Discharge/Transfer Summary | <input type="checkbox"/> Continuing Care Plan |
| <input type="checkbox"/> Progress in Treatment | <input type="checkbox"/> Demographic Information |
| <input type="checkbox"/> Other : All pertinent information for
continuity of care. | <input type="checkbox"/> AOD/Self-Harming Behaviors |
| | <input type="checkbox"/> Financial Purposes |

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to HRS Counseling Services, LLC AT: 53 Bellbrook Plaza, Bellbrook Ohio 45305. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Unless sooner revoked this consent expires at the termination of care.

I further understand that HRS Counseling Services, LLC will not condition my treatment on whether I give authorization for the requested disclosure.

HRS Counseling Services reserves the right to disclose information as permitted in this authorization in any manner we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Federal law prohibits the person or organization to which disclosure is made from making any further disclosure of information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42C.F.R Part 2.

Signature of Client _____ Date _____

Signature of Parent, Guardian or Personal Representative _____ Date _____

Check here if client refuses to sign authorization

Signature of Witness _____ Date _____