

# Soul Work Counseling

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www.soulworkcounseling.com

## Consent for Release of Information

This authorizes Soul Work Counseling to use and disclose the specific health information described below concerning:

Client: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

This form will authorize Soul Work Counseling to **Release/Obtain** information to/from the following **PERSON and/or AGENCY**:

**Name** of Person and/or AGENCY: \_\_\_\_\_

Complete **Address**: \_\_\_\_\_

**Phone Number**: \_\_\_\_\_ **FAX Number**: \_\_\_\_\_

Information from the medical record maintained for Date(s): \_\_\_\_\_

The information to be disclosed is (please check all info that you are willing to have exchanged):

<input type="checkbox"/>	History and intake information	<input type="checkbox"/>	Social/ Psychological/ Medical reports
<input type="checkbox"/>	Consultation notes/ progress reports	<input type="checkbox"/>	Chemical dependency abuse or diagnosis, history and treatment
<input type="checkbox"/>	Treatment plan, goals, and results	<input type="checkbox"/>	Medications used in treatment
<input type="checkbox"/>	Court or probation records	<input type="checkbox"/>	Other (specify)

The purpose of the information release is (please check all that apply):

<input type="checkbox"/>	Diagnosis and evaluation	<input type="checkbox"/>	To facilitate treatment
<input type="checkbox"/>	Treatment planning	<input type="checkbox"/>	Other (specify)

If I am requesting the Authorization from you for my use and disclosure or to allow another health care professional or entity to disclose information to me: (1) You have the right to inspect a copy of the protected information to be used or disclosed; (2) You may refuse to sign this authorization; and (3) I must provide you with a copy of the signed authorization at your request. You may revoke this consent at any time and that upon fulfillment of the above stated purposes(s) or within one year, this consent will automatically expire without express revocation.

By signing this authorization, you may be directing me to disclose your health information to a person or organization that does not have the same obligations to protect privacy required of health care practitioners under state and federal law. The disclosure of the information specified above may carry with it the potential for unauthorized disclosure of your protected health information and loss of protection under state and federal law.

You may request that I require the recipient of your protected health information to sign a Confidentiality Agreement in which the recipient agrees to limit its use and disclosure of your information as specified by the confidentiality agreement. If the intended recipient refuses to sign the confidentiality agreement you request, I will not release the information.

I have reviewed the Authorization and I understand it. I understand that the information used or disclosed under this Authorization may be subject to redisclosure by the recipient and may no longer be protected under federal privacy law.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent or guardian or witness

\_\_\_\_\_  
Date