Bringing Clarity to the Puzzle of Life! Counseling Connections for Change, Inc.

AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

Authorization for the use and disclosure of Protected Health Information (PHI) is only for the person or agency on this form. No responsibility can be accepted if it is made available to any other person or agency. Any duplication, transmittal, re-disclosure, or re-transfer of information is expressly prohibited.

I, _____, authorize Counseling Connections for Change, Inc. whose main office is 2549 Roy Rd., Pearland, Texas to release/exchange by phone, fax, or mail the PHI from the client record(s) of:

_____ _____

Last First Middle Date of Birth

With:_____

_____

(Name/Address of person/organization to which disclosure is to be made)

TO PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure without the specific written consent of the person to whom it pertains, or otherwise permitted by such regulations. A general authorization for the release of information is not sufficient for this purpose FOR CLIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2.

I, the undersigned, understand that a copy of this signed authorization form is as acceptable as the original.

The protected health information to be disclosed includes the following:

___ Assessment Information
___ Diagnosis
___ Treatment Planning Notes
___ Progress & Treatment Notes
___ Communicable Disease Information
___Medication
___ Psychiatric Evaluation
___ Results of Psychological Testing
___ Recommendations
___ Reason for Termination
___ Number of kept/Unkept Appointments
___Results of Clinical Polygraphs

Other (please specify): _____

For the purpose of: Continued Care; Education; Legal; Insurance; Collaboration; Other: _____

Dates of records to be released: _____

This release will expire:___ at the end of 60 days
___ at the termination of treatment
___ as of _____
(Specify Date)

I understand that I may revoke this authorization at any time to the extent that action has been taken in reliance on it. I acknowledge that this authorization is voluntary and that payment or eligibility for benefits for my health care will not be affected if I do not sign this form. I also understand that the information disclosed as a result of this authorization may no longer be protected by privacy laws and may be disclosed by the company or individual receiving the information.

_____ _____ _____

Client Signature Parent/Guardian/Legal Representative Signature Date

_____ _____

Witness Signature Date

2549 Roy Road
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