Connections Counseling, LLC

Shawna Ragan, M.S., LPC
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(907) 231-1243

Authorization for Release of Information

Name: _____ DOB: _____
(Name of client whose information is being released)

I, _____ ☐ Client ☐ Parent ☐ Legal Guardian hereby authorize Connections Counseling, LLC and/or Shawna Ragan, MS, LPC to: ____ Release To: ____ Obtain From:
Name: _____

Address: _____

Phone: _____ Fax: _____

The following written and verbal information (please initial)
_____ Admissions/Intake Summary _____ Medication Records _____ Psychosocial Assessments _____ Psychiatric Evaluation

_____ Psychological Test Results _____ Treatment Plan _____ Discharge Summary _____ Substance Abuse Assessment/Treatment

_____ School Records (specify) _____ _____ Other (specify) _____

PURPOSE OF INFORMATION (please initial)

_____ Treatment Planning _____ Personal Use _____ Continued Treatment _____ Legal Use

_____ Coordinate Treatment _____ Employment Assistance _____ Other (specify) _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment, payment, enrollment, or eligibility for benefits. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. I understand that the information released may include information regarding assessment, evaluation, and treatment. If I have questions about disclosure of my health information, I can contact Connections Counseling, LLC at 231-1243. I understand that I have a right to revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire 90 days after treatment has ended or on: _____. PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal Regulations (42 CFR Part 2) prohibiting you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. Federal Regulations state that any person who violates any provision of this law shall be fined not more than $500, in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

_____ _____
Client Signature (Optional for Minors/Adults with Guardians) Date

_____ _____ _____
Relative/Guardian/Authorized Person Printed Name Relationship to Client

_____
Witness