

Connections Counseling, LLC

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Authorization for Release of Information

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

I, _____ hereby authorize Connections
Counseling, LLC and/or Shawna Ragan, MS, LPC to:

Authorized Person or Business: _____

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