RELEASE OF INFORMATION

TANGEN counseling

TODAY'S DATE:

CLIENT'S FIRST AND LAST NAME:

DATE OF BIRTH: NAME OF REPRESENTATIVE:

The individual or their appointed representative above hereby grants permission to: ☐ RELEASE INFORMATION TO: ☐ OBTAIN INFORMATION FROM:

FIRST NAME: LAST NAME:

NAME OF ORGANIZATION: RELATION TO CLIENT:

ADDRESS:

ADDRESS:

CITY: STATE: ZIP CODE:

PHONE #: FAX #:

EMAIL:

THE TYPE OF INFORMATION ALLOWED TO BE DISCLOSED (CHECK ALL THAT APPLY):

☐ IDENTIFYING INFORMATION
☐ CLINICAL TREATMENT SUMMARY
☐ INTAKE ASSESSMENT
☐ DRUG/ALCOHOL DIAGNOSIS/TREATMENT
☐ PSYCHIATRIC EVAL / DIAGNOSIS
☐ MEDICAL / LAB REPORTS
☐ OTHER

☐ PROGRESS NOTES
☐ TREATMENT PLAN
☐ TREATMENT RECOMMENDATIONS
☐ DISCHARGE PLAN AND SUMMARY
☐ INCIDENT REPORTS
☐ FINANCIAL INFORMATION

THE PURPOSE OF THIS RELEASE OF INFORMATION IS (CHECK ALL THAT APPLY):

☐ ONGOING SERVICE COORDINATION
☐ EMERGENCY PURPOSES
☐ EVALUATION
☐ TREATMENT / SERVICE PLANNING
☐ OTHER:

☐ ONGOING COMMUNICATION
☐ REIMBURSEMENT PURPOSES
☐ ELIGIBILITY DETERMINATION
☐ COMPLIANCE WITH DMV
☐ AT REQUEST OF CLIENT/REPRESENTATIVE

THIS INFORMATION MAY BE SHARED: ☒ VERBALLY ☒ WRITTEN ☒ ELECTRONIC

I understand the following statements about my rights: 1) My records are protected under Federal and State law and cannot be released without my written permission or a court order, and I may revoke consent in writing at any time, but the revocation will not have any affect on any actions the entity took before it received the revocation; 2) Refusal to disclose information may result in improper diagnosis or treatment, or denial of coverage for a claim for health benefits, or other insurance or other adverse consequences; 3) My refusal to sign this authorization will not affect my ability to obtain treatment, benefits or services for which I am eligible; 4) I can cross out any provision on this form with which I disagree; 5) I am entitled to a copy of this authorization form; and 6) Signing this authorization is voluntary.

I understand that my records or those of the above mentioned individual are protected under state and federal regulations governing confidentiality of substance abuse and mental health records, 42CFR part 2 and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

THIS RELEASE WILL AUTOMATICALLY EXPIRE 2 YEARS FROM TODAY'S DATE ON:

CLIENT SIGNATURE: **DATE:**

WITNESS SIGNATURE: **DATE:**

Submit