

Still Waters

Counseling, Consulting, and Psychological Services

Authorization for Release/Exchange of Information

I give permission to Still Waters Counseling and _____ of that agency to release / exchange information regarding _____

Name of Client

Date of Birth

to/with _____

Name of Agency and/or Individual

Address

Contact Information (e.g. phone, fax, e-mail)

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically when its purpose has been served or in one year, whichever comes first.

Information to be Released / Exchanged

Assessments

- Initial
- Psychological
- Psychiatric
- Alcohol / Substance Abuse
- Other:

Summaries

- Quarterly
- Annual
- Discharge
- Other:

Other

- Medications
- Medical / Physical
- Treatment Concerns / Recommendations
- Progress Report
- Alcohol / Substance Abuse Treatments

Purpose of Release / Exchange

- Coordination of Treatment / Service Planning
- Determination of Eligibility for Benefits
- Requirements of Court Order
- Psychological Assessment
- Child Custody Evaluation
- Other:

Client Signature

Date

Parent / Legal Guardian Signature

Date

I refuse / withdraw permission for Still Waters to communicate with the above person or agency.

Client/Parent/Guardian Signature

Date