SEASONS
counseling of michiana

Release of Information

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has already been taken.

I, _____
Client Name

_____
Street Address

_____
City/State/Zip

_____
Client's Date of Birth

Authorize

_____
Organization

_____
Name/Title

_____
Street Address

_____
City/State/Zip

and Seasons Counseling of Michiana to release the following information to each other regarding my assessment and/or treatment, including diagnosis or treatment of alcoholism and drug abuse.

***Seasons Counseling of Michiana is authorized to release from the client's record*:**
Client must INITIAL each item to be released.

_____ Alcohol/Drug Use Information
_____ Background Information/Psychosocial History
_____ Diagnosis/Initial Assessment
_____ Attendance & Progress in Treatment
_____ Medical Information
_____ Medication
_____ Treatment Plan
_____ Discharge Summary
_____ Medication
_____ Treatment Plan
_____ Discharge Summary
_____ _____
_____ _____
_____ _____
_____ _____

Seasons Counseling of Michiana is requesting from the above named person or agency information regarding:
Client must INITIAL each item to be released.

_____Alcohol/Drug Use Information
_____Diagnosis/Initial assessment
_____Background Information/Psychosocial History
_____Attendance & Progress in Treatment
_____Treatment Plan
_____Psychiatric Assessment
_____Medication
_____Psychological Testing/Assessment
_____Discharge Summary
_____Current medical problems
_____Relevant medical history
_____Medications
_____Academic Record
_____ School Conduct
_____ School Attendance
_____ _____
_____ _____
_____ _____

Send information to Seasons Counseling of Michiana, attention: _____

Purpose of Disclosure:

_____Treatment of Client
_____Response to insurance or managed care company
_____Comply with order of the court
_____Response to referral source

This consent is subject to revocation at any time except to the extent that the information has already been released by my consent. The consent may be revoked at any time by giving notice to the person or organization making disclosure. If not previously revoked the consent will terminate on _____(date) or after 1 year from the date signed, whichever comes first.

_____ _____ _____
Signed Relationship to Client Date Signed

Note to recipient: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). These rules prohibit you from making any further disclosure of this information unless disclosure is expressly permitted by the written consent of the person to whom the information pertains.