AUTHORIZATION FOR RELEASE OF CLIENT INFORMATION

CLIENT NAME: _____ DATE OF BIRTH: _____

CLIENT SOCIAL SECURITY NUMBER (last 4 digits): _____

This authorizes the disclosure of information between:
THE COUNSELING SOURCE, INC.
10921 Reed Hartman Highway, Suite 133
Cincinnati, OH 45242

AND

_____
_____
_____
_____

I authorize the exchange of written and/or verbal information with the above party(ies) to facilitate the successful collaboration, treatment planning, and continuity of care for the above-named client. This exchange may include information communicated verbally, in writing, and through electronic means (including texting).

This authorization includes release of records relating to ("X" appropriate boxes):

- ❑ Diagnosis and/or treatment for alcohol and/or drug abuse
- ❑ AIDS/AIDS Related Complex (ARC) diagnosis or treatment
- ❑ HIV test results
- ❑ Diagnosis and/or treatment relating to other communicable diseases

Indicate here any additional exceptions or exclusions, if any, to information released: _____

_____

My refusal to sign this authorization will NOT affect my ability to obtain treatment or payment. This authorization will remain effective for the duration of the treatment unless an earlier date or condition/event is specified here: _____
However, I understand that I have the right to revoke this authorization in writing, at any time, and that the revocation will be effective except to the extent that The Counseling Source, Inc. has already taken action in reliance on my authorization.

_____ _____
DATE CLIENT SIGNATURE (if 18 years or older)

_____ _____
DATE PARENT/GUARDIAN/PERSONAL REPRESENTATIVE SIGNATURE

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here: _____

_____ _____
DATE SIGNATURE OF THE COUNSELING SOURCE STAFF PERSON FACILITATING REQUEST

NOTE: This authorization may be revoked at anytime except to the extent that action has already been taken. I wish to revoke this Authorization for Release of Client Information.

_____ _____
DATE PARENT/GUARDIAN/PERSONAL REPRESENTATIVE SIGNATURE

My written statement that I want to revoke my authorization should be delivered to: Director of Quality Assurance, The Counseling Source, Inc. 10921 Reed Hartman Hwy, Suite 133, Cincinnati, OH 45242

Note: This information has been disclosed to you from records whose confidentiality is protected from disclosure by State and Federal law. OCR 5122.31, 42 CFR Part 2, and/or OCR 3701.243 prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by State and Federal Laws. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.