CORE
COUNSELING

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, _____, authorize Core Counseling Services to disclose to and/or obtain from (Person/Entity Listed Below) information pertaining to my mental health.

Name/Facility: _____

Address: _____

City/State/Zip: _____

Office Phone: _____ Fax: _____

E-mail: _____

Preferred Method of Release: ☐ Mail ☐ E-Mail ☐ Fax ☐ E-Fax ☐ Other: _____

The information to be disclosed should include (or be limited to):

_____ Diagnosis _____ Treatment Summary _____ Psychological Evaluation Report

_____ Demographics _____ Treatment Notes _____ Dates of Attendance

_____ Other: _____

I understand that I have the right to revoke this authorization in writing at any time by sending written notification to Core Counseling Services. I further understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. Under these circumstances, I release Core Counseling Services from all claims and responsibility which result from such a release.

Unless revoked sooner, this authorization will automatically expire exactly one year from the date of signing.

I agree that a photocopy of this form is acceptable, but it must be individually signed by me, the releaser, and a witness.

I have been informed of the risks to privacy and limitations to confidentiality of the use of electronic means of information transfer and I accept these.

I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request.

NOTICE TO RECEIVING FACILITY OR PROVIDER: The information contained in the released documents is legally privileged information and is not to be redisclosed or released to any person or entity without the expressed written consent of the patient. Any unauthorized disclosure, copying, and/or distribution of these records is strictly prohibited.

_____

Name of Patient/Parent/Guardian/Representative (Please Print)

_____

Signature of Patient/Parent/Guardian/Representative Date

I, _____(provider) have discussed the issues above with the patient and/or legal representative. My observations of behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent to the release of the specified health information.

_____

Signature of Provider Date