FOCUS FORWARD
COUNSELING AND CONSULTING, INC.
SUPPORT | GROW | SUCCEED

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Release of Information

Name of client: _____ Date of Birth: _____

I am your client. I am requesting a copy of my medical records as designated under 42 USC §17921(5) and 45 CFR §164.524(a), including psychotherapy notes as designated under 45 CFR §164.524(a)(1)(i) and 45 CFR §164.501.

If you do not wish for the entire medical records to be shared, the release can be limited to the following items:

( ) Treatment Attendance ( ) Level of Participation ( ) Treatment Plan ( ) History ( ) Discharge Summary ( ) Progress Notes ( ) Psychiatric Reports ( ) Medical Reports ( ) Educational Reports ( ) Disciplinary Reports ( ) Legal Documents ( ) Diagnosis ( ) Verbal Communications ( ) Psychological Testing Reports

( ) Other: _____

The disclosure of information is required for the following purpose(s):

( ) Coordination of Treatment ( ) Referral ( ) Other: _____

I authorize Focus Forward Counseling and Consulting, Inc. to release information contained in my medical record (including, information about mental health services) to the following party:

Name_____ Phone Number: _____ Fax Number: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Focus Forward Counseling and Consulting, Inc. While we will not release any additional information after we receive your revocation, we may have already released the information based on your original authorization. Your protected health information will be disclosed as specified in this authorization. This authorization will expire 365 days from the date of signature, or until we have completed the disclosures you have requested, whichever is shorter. Once released by us, we can no longer guarantee its protection against disclosure and disclaim any responsibility for future disclosures.

BY SIGNING, YOU AGREE YOU UNDERSTAND, AND AGREE TO BE BOUND BY, THE PRECEDING TERMS:

Client:_____ Date: _____

Signature of client or responsible party if client is a minor or is otherwise unable to sign for themselves.