

## **AUTHORIZATION FOR RELEASE OF INFORMATION**

	inseling Services,	PLLC to release and disclose information	from the clinical record
of:Name of client/recipie	nt of mental health servic	Date of birth	AND THE RESIDENCE OF THE PARTY
to, and allow such information to b	e inspected and co	ppied by:Facility/Provider/	DCD.
		racinity/Provider/	rcr
		Facility/Provider/PCP	Address
Nature of information to be disclos	ed:	State specific nature of information to be disclosed	
		State specific nature of information to be disclosed	
For the purposes of		State specific purpose of information to be disclosed	
Information to be released and/or e information as verified by CLIEN	nemanged merades	s arry available substance use/abuse of fift	//Infectious disease
Counseling Services, PLLC office.	I understand that reliance on such a	rization, in writing, at any time by sending a revocation is not valid to the extent that uthorization. This authorization is valid O	Jodi Province Counselin
A copy of this release shall have the been notified that release/disclosure exceptions as detailed in the General	e of information m	effect as the original. By signing below I a nay only occur with a consent unless it is a 5 CFR 164.512 of HIPAA.	acknowledge that I have in emergency or for other
Client Signature 12 yrs. or older	Date	Parent/Guardian Signature	Date
Witness	Date	Relationship to Client	
who consented to this disclosure sp	pecifically consent	EYou may not re-disclose any of this infocts to such re-disclosure. I understand that and, if that occurs, the information n	t there is a potential for