



6641 N. High Street, Suite 205  
Worthington, Ohio 43085  
(614)504-4466 | (614)504-4464

### Authorization to Release Information

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize Foundations Family Counseling and \_\_\_\_\_ to communicate about the following protected information from my clinical record (those checked):

To be released by Foundations Family Counseling:

- |                                                   |                                                    |
|---------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Attendance in Counseling | <input type="checkbox"/> Diagnosis                 |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Treatment Recommendations |
| <input type="checkbox"/> Alcohol/Drug information | <input type="checkbox"/> Other (specify): _____    |
| <input type="checkbox"/> Psychosocial History     |                                                    |

To be released to Foundations Family Counseling:

- |                                                            |                                                        |
|------------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Legal Documents                   | <input type="checkbox"/> Summary of Treatment          |
| <input type="checkbox"/> Work/School Attendance            | <input type="checkbox"/> Treatment Recommendations     |
| <input type="checkbox"/> Medical History/Treatment         | <input type="checkbox"/> IEP/Multi-Factored Evaluation |
| <input type="checkbox"/> Case Plan                         | <input type="checkbox"/> H&P Report                    |
| <input type="checkbox"/> Work/School Performance           | <input type="checkbox"/> Discharge Report              |
| <input type="checkbox"/> Psychiatric/Psychological History | <input type="checkbox"/> AOD Treatment/History         |
| <input type="checkbox"/> Vocational Evaluation             | <input type="checkbox"/> Other (specify): _____        |

The purpose of this exchange of information is to:

- Formal evaluation       Facilitate treatment       Other: \_\_\_\_\_

The information exchanged should reflect material collected:

- In the last six months       In the last five years  
 In the last year       Since first contact with the client

I may revoke my consent to release this information at any time except to the extent that action will have been taken or information released prior to the revocation of my consent. I understand that treatment is generally not a condition of my signing an authorization to release information. This authorization form is valid until ninety days after last contact. Generally, this information may not be re-released, but I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

This information has been disclosed from records whose confidentiality is protected by Ohio Revised Code 5122.31. This information has been disclosed to you from records protected by Federal confidentiality rules. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part II. A general authorization for the release of medical or other information is not sufficient for this purpose. These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_