Foundations
FAMILY COUNSELING

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:

[ ] Any/All Information, as Appropriate
[ ] Attendance in Counseling
[ ] Psychological Evaluation
[ ] Alcohol/Drug information
[ ] Diagnosis
[ ] Report of Current Functioning
[ ] Treatment Recommendations
[ ] Billing & Scheduling Information
[ ] Other (specify): _____

To be released to Foundations Family Counseling:

[ ] Any/All Information, as Appropriate
[ ] Legal Documents
[ ] Work/School Attendance
[ ] Medical Records
[ ] School Records
[ ] Psychiatric/Psychological Reports
[ ] Summary of Treatment
[ ] Report of Current Functioning
[ ] Treatment Recommendations
[ ] IEP/Multi-Factored Evaluation
[ ] Alcohol/Drug information
[ ] Other (specify): _____

The purpose of this exchange of information is:

[ ] Coordination of care
[ ] Formal evaluation

The information exchanged should reflect material collected:

[ ] Since first contact with the client
[ ] in the last _____ year(s)

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 six months 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.

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Witness: _____