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:

[ ] Attendance in Counseling
[ ] Psychological Evaluation
[ ] Alcohol/Drug information
[ ] Psychosocial History
[ ] Diagnosis
[ ] Treatment Recommendations
[ ] Other (specify): _____

To be released to Foundations Family Counseling:

[ ] Legal Documents
[ ] Work/School Attendance
[ ] Medical History/Treatment
[ ] Case Plan
[ ] Work/School Performance
[ ] Psychiatric/Psychological History
[ ] Vocational Evaluation
[ ] Summary of Treatment
[ ] Treatment Recommendations
[ ] IEP/Multi-Factored Evaluation
[ ] H&P Report
[ ] Discharge Report
[ ] AOD Treatment/History
[ ] 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 year
[ ] In the last five years
[ ] 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 six months from application date or _____ (if less than six months). 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: _____