Hope Restored
COUNSELING SERVICES LLC

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Phone (513)683-HOPE Fax (513)683-4108

Authorization for Release of Information

(PLEASE PRINT)
CLIENT'S NAME: _____ D.O.B. _____
(FIRST) (MIDDLE) (LAST)
Regarding the use or disclosure of protected health information, I hereby grant my permission for HRCS/

_____ to:
(Counselor name, credentials)

____ Release information to and/or ____ Receive information from:

Name of Agency and/or Individual: _____

Contact Information of Agency/Individual: _____

INFORMATION TO BE DISCLOSED:

____ Clinical Diagnosis
____ Drug/Alcohol Information
____ Educational Information
____ Initial Evaluation
____ Individual Treatment Plan
____ Treatment Summary
____ Recommendations
____ Other:_____

FOR THE PURPOSE OF:

____ Collaboration/Consultation
____ Psychological Evaluation
____ Continuity of Care

____ Other: _____

I UNDERSTAND:

1) That the information used or disclosed may be subject to redisclosure by the agency or individual receiving it and no longer protected by federal privacy regulations. However, this information will not be re-released by HRCS without my written consent.
2) That I may withdraw or refuse this consent in writing at any time. However, if I revoke this authorization, it will not have any effect on actions by HRCS in reliance on it before revocation.
3) I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

THIS AUTHORIZATION WILL EXPIRE:

____ On (Date): _____
____ Other: _____

Client/Parent/Guardian/Authorized Representative **Signature:** _____ **Date:** _____

Parent/Guardian/Authorized Representative **Printed Name:** _____(if applicable)

Representative's authority to act on behalf of client: _____(if applicable)

Witness **Signature**: _____ **Date:** _____