Release of Information

HEALING TIDES COUNSELING

Client's name: _____

Please Initial **I authorize Healing Tides Counseling, LLC to:**

____ Send

____ Receive

Please Initial **The following information:**

____ Social, medical, or psychological reports

____ Medication(s) used in treatment

____ Treatment goals and results

____ Information about drug and/or alcohol abuse

____ Mental health information

____ HIV/AIDS related records

To / From: _____

(Who is Healing Tides Counseling releasing information to or getting information from?)

Your relationship to client:

☐ Self

☐ Parent/legal guardian

☐ Personal representative

Please Initial **The above information will be used for the following purposes:**

____ Planning appropriate treatment or program

____ Coordination of care

____ Treatment support

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Signature: _____ **Date:** _____

Witness: _____ **Witness Date:** _____

(if client is unable to sign)