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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Please read carefully and complete the entire authorization form. Use clear and legible writing, and be as specific as you can.

Name of Client: ____ DOB: ____________________

*****Duluth Counseling Center may disclose/exchange information to the following recipient:***

Recipient Name / Name of Organization: ____
Address: ____
City / State / Zip Code: ____
Recipient Phone Number: ____
Recipient Fax Number: ____

*****I authorize Duluth Counseling Center to disclose/exchange the following information for the following date(s): From ____ / ____ / ______ To ____ / ____ / ______ . (Check all that apply)***

- ☐ Presence in Treatment (verification of admission/discharge dates)
- ☐ Progress Notes (including mental health/psychotherapy notes)
- ☐ Diagnosis
- ☐ Intake and Assessment
- ☐ Treatment/Service Plan
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Physical Examination
- ☐ Education / School Records
- ☐ Other *(Specify)*: ____

***** I authorize Duluth Counseling Center to use the following methods to disclose/exchange information: (Check all that apply)***

☐ Fax ☐ Mail ☐ Verbal Exchange ☐ Email

***** The purpose of this authorization is: (Check all that apply)***

- ☐ Treatment / Service Plan
- ☐ Continuation / Transfer of Care
- ☐ Litigation / Legal
- ☐ Disability Determination
- ☐ Insurance / Benefits
- ☐ Personal Use / Review
- ☐ Other: *(Specify)*: ____

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***** I understand:***

1. The expiration date of this authorization is one year.
2. I may revoke this authorization at any time by notifying the releasing organization in writing. It will be effective on the date notified except to the extent action has already been taken.
3. This authorization is valid for records prior to and after the date signed.
4. I may inspect and receive a copy of the material to be disclosed.
5. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal Privacy standards.
6. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
7. I understand if I agree to sign this authorization I must be provided with a signed copy of the form.
8. A photocopy or fax of this document is valid as the original.
9. I understand that this information may be transmitted via email.
10. My records are protected under state and federal confidentiality regulations and cannot be disclosed without written consent unless otherwise provided for in the regulations.
11. I am <u>not</u> giving permission for the receiver of this information to redisclose this information to any third party.
12. I have had the opportunity to review and understand the content of this authorization form.
13. By signing this authorization, I am authorizing Duluth Counseling Center to disclose/receive my above identified protected health information.

____ ________________

Signature of Client Date

***** If the client is a <u>minor or unable to sign</u>, please complete the following section:***

Authority of representative to sign on behalf of the client:

☐ Parent ☐ Legal Guardian ☐ Other: *(Specify)*: ____________________________

____ ________________

Print name of Parent, Legal Guardian, or Authorized Representative Relationship

____ ________________

Signature of Parent, Legal Guardian, or Authorized Representative Date