

Release of Information

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KAY COUNSELING PLLC

Client Name: _____ Date of Birth _____
 Address (street, city, state, zip) _____

I hereby authorize: Kay Counseling, PLLC and my therapist _____

And

Name _____
 Address _____
 Phone _____ Fax _____
 Relationship to client _____

TO DISCLOSE TO AND COMMUNICATE TO ONE ANOTHER information contained in my patient/student records, including if any, alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Par 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA); social services records; psychological services records, including communications made by me to a social worker or psychologist; and all information defined by statute governing Human Immunodeficiency Virus (HIV), HIV Test, Acquired Immunodeficiency Syndrome (AIDS), and AIDS-related complex (ARC), only under the conditions listed below:

SPECIFIC INFORMATION TO BE DISCLOSED

<input type="checkbox"/> ASSESSMENT/DIAGNOSIS <input type="checkbox"/> COMMUNICATION EXCHANGE <input type="checkbox"/> PSYCHOSOCIAL/COUNSELING <input type="checkbox"/> TREATMENT PLAN/CONTRACT <input type="checkbox"/> LAB RESULTS <input type="checkbox"/> ADMISSION/DISCHARGE DATA SET <input type="checkbox"/> SCHOOL/WORK RECORDS <input type="checkbox"/> SCHOOL/WORK SOCIAL INVOLVEMENT	<input type="checkbox"/> PROGRESS REPORTS <input type="checkbox"/> RECOVERY PLAN <input type="checkbox"/> DISCHARGE SUMMARY <input type="checkbox"/> DR. DISCHARGE SUMMARY <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> REAUTHORIZATION FORMS <input type="checkbox"/> OTHER PERTINENT INFORMATION (Specify) _____ _____ _____ _____ Dates of Service _____
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PURPOSE AND NEED FOR SUCH DISCLOSURE

<input type="checkbox"/> CONTINUATION OF CARE <input type="checkbox"/> SCHOOL/WORK <input type="checkbox"/> REFERRAL FOLLOW-UP <input type="checkbox"/> FAMILY NOTIFICATION	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> RETURN TO SCHOOL/WORK <input type="checkbox"/> OTHER (Specify) _____ _____
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I understand that my medical record may contain reports, test results and notes that only a care provider can interpret. I understand and have been advised that I should contact my care provider regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record. I will not hold Kay Counseling, PLLC, or counselors liable for any misinterpretation of the information in my medical record as a result of not having consulted my care provider for the correct interpretation. I understand that generally my treatment may not be conditioned on whether or not I sign an authorization form, but that in certain limited circumstances I may be denied treatment if I do not sign an authorization form. This authorization is subject to a written revocation at any time except in those circumstances in which the counseling center has taken certain actions in reliance on such authorization. However, this authorization shall be valid no longer than is reasonably necessary to accomplish the purpose of the actions for which it was given. This authorization will automatically expire 12 months from the end of involvement in our programs or as specified in the revocation below.

 Signature Date Witness Date

Relationship to Student _____ If student is a minor or incapable of signing, a copy of the appropriate legal documentation is attached if applicable. If I have joint custody, I have discussed this matter with the other legal guardian(s).

DRIVERS LICENSE/IDENTIFICATION VERIFIED

REVOCAION (optional) – This authorization is revoked for the following specified dates, events, or conditions.
 Date: _____ Event: _____ Condition: _____