Release of Information Form

KPCC Counseling

Client _____

SS Number _____

Today's Date _____

I authorize the release of information about me FROM:

Name: _____

Address: _____

_____

Tel/Fax: _____

I authorize the release of information about me TO:

Name: _____

Address: _____

_____

Tel/Fax: _____

The items covered by this release are part of the Designated Record Set, and are initialed below:

Intake and Symptom Assessment	Treatment	
___ Phone Intake	___ Initial Treatment Plan	___Psychiatric Records
___ Client Info and Consent	___ Progress Notes	___Psychological Testing
___ Medical History	___ Closing Summary	___Other_____
___ Symptom Checklist	___ Critical Areas Forms	
___ Client/Therapist Agreement	___ Misc worksheets	

This information is being released for the following reasons: _____

____ (initials) At my request, KPCC may send these records via encrypted email.
I understand that with any email there is no guarantee of complete security.

____ I authorize this release to include information regarding drug and alcohol use or treatment.
I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality or Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164. I understand that my health information specified above will be disclosed pursuant to this authorization, that the recipient of the information may re-disclose the information and it may no longer be protected by the HIPAA privacy law. The Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from re-disclosure. I understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that this consent will expire in one (1) year unless otherwise specified.

____ I authorize this release to include information related to my HIV/AIDS status.
I understand that KPCC will release records of couples or family therapy sessions only with the signed authorizations of all involved persons age of 18 and older. I recall that I have signed an agreement saying that I will not use KPCC records or therapists for testimony in divorce and custody disputes, or in injury or personal damages lawsuits, and that neither I, the client, nor my attorney, nor anyone else acting on your behalf will call on KPCC staff to do so. KPCC will not release records if I attempt to breach this agreement.

_____ _____
Signature of Client Date

_____ _____
Signature of Witness Date