RELEASE OF INFORMATION AUTHORIZATION
Behavioral Health Treatment

Client Name: _____ Client DOB: _____ /_____ /_____
Parent/Guardian Name: _____ Parent DOB: _____ /_____ /_____

Client authorizes Family Guidance Centers to disclose to and/or obtain the selected information from:
Provider Name: _____
Street Address: _____
City/State/Zip: _____
Phone: ( ) _____ Fax: ( ) _____
Email Address: _____

DESCRIPTION OF INFORMATION TO BE DISCLOSED
Please initial each item that you allow to be disclosed.

_____ Assessment
_____ Diagnosis
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Progress in Treatment
_____ Other _____
_____ Other _____

PURPOSE: The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.
REVOCATION: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Family Guidance Centers' Administration at contact@familyguidancecenters.com. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.
EXPIRATION: Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated: _____
FORM OF DISCLOSURE: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner we deem appropriate and consistent with applicable law and our Privacy Policy, including, but not limited to, verbally, in paper format, and electronically.
REDISCLOSURE: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

_____ _____
Client or Parent/Guardian Signature Date

_____ _____
Clinician/Witness Date