Sandcastle Kids Counseling

AUTHORIZATION TO EXCHANGE, REQUEST, OR RELEASE INFORMATION

I, _____ hereby request and authorize Sandcastle Kids Counseling,

❑ To Exchange with ❑ To Release to ❑ To Obtain from	Name of Organization: _____ Address: _____ Phone Number: _____ Fax Number: _____

❑ Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness or drug or alcohol abuse.
❑ Psychological evaluation(s) or testing records, and behavioral observations or checklists completed by any staff member or by the patient.
❑ Psychiatric evaluations, reports, or treatment notes and summaries.
❑ Treatment plans, recovery plans, aftercare plans.
❑ Admission and discharge summaries.
❑ Social histories, assessments with diagnoses, prognoses recommendations, and all similar documents.
❑ Information about how the patient's condition affects or has affected his or her ability to complete tasks, activities of daily living, or ability to work.
❑ Workshop reports and other vocational evaluations and reports.
❑ Billing records.
❑ Academic or educational records.
❑ Report of teachers' observations.
❑ Achievement and other tests' results.
❑ A letter containing dates of treatment(s) and a summary of progress.
❑ All of the above.
❑ Other _____

_____ (Name of Client) ____/____/_____ (Date of Birth)

I authorize the source named above to speak by telephone with the Crystal Crosby, LPC, NCC, CCMHC, about the reasons for my/the patient's referral, any relevant history or diagnoses, and other similar information that can assist with my/the patient's receiving treatment or being evaluated or referred elsewhere.

I understand that no services will be denied me/the patient solely because I refuse to consent to this release of information, and that I am not in any way obligated to release these records. I do release them because I believe that they are necessary to assist in the development of the best possible treatment plan for me/the patient. The information disclosed may be used in connection with my/the patient's treatment.

This request/authorization to release confidential information is being made in compliance with the terms of the Privacy Act of 1974 (Public Law 93-579) and the Freedom of Information Act of 1974 (Public Law 93-502); and pursu-ant to Federal Rule of Evidence 1158 (Inspection and Copying of Records upon Patient's Written Authorization). This form is to serve as both a general authorization, and a special authorization to release information under the Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255), the Comprehensive Alcohol Abuse and Alcoholism Pre-vention, Treatment and Rehabilitation Act Amendments of 1974 (Public Law 93-282), the Veterans Omnibus Health Care Act of 1976 (Public Law 94-581), and the Veterans Benefit and Services Act of 1988 (Public Law 100-322). It is also in compliance with 42 C.F.R. Part 2 (Public Law 93-282), which prohibits further disclosure without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulations. It is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191.

In consideration of this consent, I hereby release the source of the records from any and all liability arising there-from.

This request/authorization is valid during the pendency of any claim or demand made by or in behalf of me/the patient, and arising out of an accident, injury, or occurrence to me/the patient. I understand that I may void this request/ authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive. If I do not void this request/authorization, it will automatically expire in 1 year from the date I signed it.

I agree that a photocopy of this form is acceptable, but it must be individually signed by me, the releaser, and a witness if necessary.

I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these.

I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request.

Signature of client	Printed name	Date

Signature of parent/guardian/representative	Printed name	Relationship	Date

Signature of witness	Printed name	Date

CONFIDENTIALITY NOTICE: This release may contain information that is privileged, confidential or otherwise protected from disclosure. It is intended only for the use of the authorized individual as indicated in this release. If you are not the intended recipient of this release, please notify the sender immediately by return e-mail, purge it and do not disseminate or copy it.