Crosswinds Center for Personal and Professional Development, LLC

Release of Information Consent

Client's Name: _____

Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ DOB: _____

I, _____, authorize _____ to:
____ (send) ____ (receive) the following ____ (to) ____ (from)

Name: _____

Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____ Fax Number: _____

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR *PSYCHOTHERAPY NOTES.

____ Academic testing results
____ Behavior programs
____ Progress reports
____ Intelligence testing results
____ Medical reports
____ Personality profiles
____ Psychological reports
____ Psychological testing results
____ Service plans
____ Summary reports
____ Vocational testing results
____ Entire record, except progress notes
____ *Psychotherapy Notes
____ Other, specify _____

The above information will be used for the following purposes:
____ Planning appropriate treatment or program
____ Continuing appropriate treatment or program
____ Determining eligibility for benefits or program
____ Case review ____ Updating files
____ Other (specify) _____
("At the request of the individual" is all that is required if you are my client and you do not desire to state a specific purpose.)

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization. This consent will expire on _____.

Your relationship to client: __Self __Parent/legal guardian __Personal representative
__Other (describe)_____

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: _____ Date: _____/____/_____

Parent/guardian/personal representative (if applicable)

Signature: _____ Date: _____/____/_____

Witness Signature: _____ Date: _____/____/_____