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REQUEST/AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS & INFORMATION

RE: Client Name _____
Client Date of Birth _____
I hereby authorize 4Directions Counseling, LLC to **obtain** information from:
Name: _____
Phone: _____
Address: _____
Fax: _____

Confidential record information and/or testing results on the above client for the following purpose(s):
__ Continuity of Care __ Insurance or other 3rd party reimbursement
__ Pending legal action (i.e. custody evaluation, disability) __ Other _____

This information to be disclosed is marked by an X in the boxes below:
___ All pertinent records below
___ Intake and discharge summaries ___ Medical history and evaluation(s)
___ Mental health evaluations ___ Development and/or social history ___ Progress notes ___ Treatment or closing summary ___ Telephone consultations ___
Other _____
HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: [ ] **Do Not Release**

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the office. Your revocation, however, will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
This consent will expire automatically one year from the date on which it is signed.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian/Representative Date

To Disclosee: This information has been disclosed to you for your records alone. Confidentiality is protected by Federal Law. Federal Regulation 42FR, part 2, prohibits you from making any further disclosure of this information without the specific written consent of the person whom it pertains or as provided by such regulations.