PATIENT'S ID#_____

Forensic Consultation & Counseling Service, LLC

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AUTHORIZATION TO USE OR DISCLOSE ALCOHOL, HEALTH, OR DRUG INFORMATION

PATIENT NAME _____ Date of Birth_____

PATIENT ADDRESS_____Phone _____

I AUTHORIZE FORENSIC CONSULTATION & COUNSELING SERVICE TO OBTAIN MY HEALTH INFORMATION FROM AND TO RELEASE INFORMATION TO:

NAME:_____PHONE:_____ FAX:_____

ADDRESS: _____ City_____ State: _____Zip Code:_____

DESCRIPTION OF ***SPECIFIC RECORD INFORMATION*** THAT MAY BE RELEASED/REQUESTED :

*___ (ASSESSMENT & DIAGNOSIS)

*_.__ (ONGOING TREATMENT)

*_.__ (ATTENDANCE/PRESENCE IN TREATMENT

*_.__ (MEDICAL INFORMATION)

*_.__ (DISCHARGE SUMMARY /PLAN)

*_.__ _ (DEMOGRAPHIC INFORMATION)

*_.__ (ENTIRE MENTAL HEALTH RECORD)

*_____ (OTHER: ***SPECIFY***)

*_.__ (PSYCHOSOCIAL/PSYCHOLOGICAL EVALUATION)

*___ _ (PLAN OF CARE/PLAN OF CARE REVIEW)

*_.___ (CURRENT TREATMENT UPDATE)

*_.__ (EDUCATIONAL INFORMATION)

*___ (TREATMENT RECOMMENDATIONS)

*__ _ (PROGRESS NOTES)

*___ (TESTING RESULTS)

*_____ (ER REPORT)

DATES: FROM _____ TO _____

PURPOSE OF DISCOURSE:

I UNDERSTAND THAT MY RECORDS ARE PROTECTED UNDER THE FEDERAL REGULATIONS GOVERNING CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENTS RECORDS, 42 CFR PART 2, AND CANNOT BE DISCLOSED WITHOUT MY WRITTEN CONSENT UNLESS OTHERWISE PROVIDED FOR IN THE REGULATIONS. *_____ (***INITIALS FROM CLIENT***)

REVOCATION STATEMENT:

I UNDERSTAND THAT THIS AUTHORIZATION CAN BE REVOKED IN WRITING AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON IT, AND THAT IN ANY EVENT THIS CONSENT EXPIRES AUTOMATICALLY ONE YEAR FROM THE DATE SIGNED OR UNLESS STATED_____(***INITIALS FROM CLIENT***).

SIGNATURE OF CLIENT_____ DATE_____

SIGNATURE OF STAFF_____ DATE_____

I HEREBY **REVOKE** THIS RELEASE EFFECTIVE IMMEDIATELY.

SIGNATURE OF CLIENT_____ DATE_____

SIGNATURE OF STAFF_____ DATE_____

Rev 1/17/19