Consent for Release of Information

Client name: _____
DOB:_____

I, _____ hereby authorize KidsHeart Counseling, LLC at 463 Allenby Drive, Marysville, Ohio (937-209-0088) to:

_____ Release _____ Exchange _____Receive copies of medical and any other treatment information to/ with:

(Please initial)

_____ Physician (Name:) _____

_____ Union County Job and Family Services

_____ Union County Board of Developmental Disabilities

_____ Union County Court and Probation (Specify: _____ Juvenile _____ Common Pleas _____ Municipal)

_____ School (Name:)_____

_____ Family/ support person _____

_____ Other _____

Including but not limited to information concerning hospitalizations, drug abuse or drug related conditions, alcoholism, psychological and psychiatric conditions, family information, mental health information, AIDS diagnosis and testing, or permit review of the same provided that such a release is limited specifically to material in the following nature and extent:

(Check all that apply)

_____ Presence in treatment _____ Progress in treatment _____ Discharge information
_____ Evaluations/ Assessment _____ Diagnosis _____ Medical Records
_____ Clinical Records _____ Treatment plan _____ Other (_____)
_____ All pertinent medical, mental health and addictions related treatment information

Purpose for Disclosure:
(Check all that apply)

_____ Family/ support person's involvement in treatment _____ To assist with continuity of care
_____ Coordination of treatment efforts _____ Linking with community resources
_____ Fulfilling conditions of court order, probation, parole _____ Other (_____)

Amount of Information to be Disclosed:

_____ Information Covering the most recent admission _____ Information covering current and past treatment
_____ Information covering the previous three months _____ Other (specify:_____)

Specific Exclusions: This information is being disclosed to the above-captioned individual(s)/ organization(s) for the above stated purpose from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that this authorization may be revoked in writing at any time except to the extent that action has been taken prior to the revocation. This consent will expire one hundred and eighty days (180) following the last date of service at KidsHeart Counseling or sooner at my election if indicated:_____. I acknowledge that I have read and fully understand this authorization as it applies to me. I also acknowledge if my referral for treatment is court-ordered, I cannot revoke this release to court personnel.

Signature of client_____ Date:_____

Signature of parent/ guardian:_____ Witness: _____