YOUR STORY COUNSELING

Release of Information

JEFFREY MEUSER (503) 804-7783

11630 SE 40TH AVE. MILWAUKIE OR. 97222

AUTHORIZATION TO RELEASE COUNSELING INFORMATION

Client Information	Name _____ Date of Birth _____ Address _____ City _____ State _____ Zip Code _____ Phone Number_____ Name _____ Date of Birth _____ Address _____ City _____ State _____ Zip Code _____ Phone Number_____
Clinic/Health Care Provider Who has the information to be released?	Name _____ Address _____ City _____ State _____ Zip Code _____ Phone Number_____ Fax Number _____
Receiving Party Who will the information be released to?	Name _____ Relationship to Client _____ Address _____ City _____ State ____ Zip Code _____ Phone Number_____ Fax Number _____
Information to Be Released What will be released?	☐ Whether the client is in treatment or not ☐ Prognosis (diagnosis, opinion of how treatment will benefit client, general peculiarities of case) ☐ Brief statement regarding progress (client's denial, client's understanding of their condition, progress or lack of progress on goals, cooperation with treatment plan and rules) ☐ Brief statement regarding relapse and frequency of relapse (cannot identify specific drugs)
Purpose of Release	☐ Referral to other services ☐ Coordination of care

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Why is information being released?	☐ Consultation with Doctor ☐ Consultation with other mental health provider ☐ Transfer of care ☐ Other: _____

Signature of Client _____ **Date**_____

Signature of Client _____ **Date** _____

Signature of Clinician _____ Date_____

Signature of Clinician _____ Date_____

This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____. This authorization may be canceled in writing at any time. A photocopy/fax of this authorization will be treated in the same way as an original. Your signature indicates that you have read and understand this form, and authorize release of your information as described above. I understand that I may refuse to sign this authorization and that refusal to sign will not affect treatment.

FOR THE RECIPIENT OF THE INFORMATION: If any of the requested records contain information regarding alcohol or drug abuse treatment, it may be protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or 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 fo