Viewpointe Counseling

441 Swartz Ct, Ionia, MI 48846 (O) 616-523-6537 (F) 616-523-6536

Release of Confidential Information

I, ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do authorize the release of information regarding; ­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Date of Birth: ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Client name) (Client DOB)

**Between the following parties:**

Dana Beech, LMSW, Megan Ledin, LMSW, Chris Doucette, LMSW

Perla Garza, LMSW, Michelle Brockington, LLMSW, Alex Thompson, LMSW

Candy Straubel-Sower, LMSW, CAADC, Antione Trent, LMSW, Derek Robertson, LMSW

**And:**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The purpose of this sharing of information is for: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following information from the client’s record may be disclosed:

\_\_\_\_ Assessments \_\_\_\_ Progress Notes \_\_\_\_Treatment Plans/Goals

\_\_\_\_ Diagnosis \_\_\_\_ Closing Documentation \_\_\_\_Substance Use/Abuse

\_\_\_\_ Psychiatric/Physiological Evaluation \_\_\_\_ Labs/Prescriptions \_\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ TX Summaries and/or Reports \_\_\_\_ Status/Service Participation \_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Medical Information \_\_\_\_ School Records

This release of confidential information expires on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization shall remain in effect for ONE year or until termination of treatment, whichever occurs first.

The specific PURPOSE AND NEED for such disclosure would be in the case of emergency or to reschedule or change an appointment when the client is not available.

I understand that my records are protected under the Federal and State law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical, mental, and/or emotional illness, including treatment of psychiatric, alcohol or chemical dependency for any admission; diagnosis, prognosis, testing for and/or treatment for HIV infection, Acquired Immunodeficiency Syndrome (AIDS) or Acquired Immunodeficiency Syndrome Related Complex (ARC).

A true and exact photocopy/facsimile of this form shall be acceptable for releasing information between the noted parties.

Client/Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I may revoke this release at any time. Once revoked, verbally or in writing, all contact from that point forward between the above parties will cease.