Authorization for Release of Confidential Information

Brotherton Counseling, LLC

Primary Client Name: _____
Primary Client Date of Birth: _____ / _____ / _____
Primary Client Social Security Number: _____ - _____ - _____
Other Client Name(s):
_____ ; _____ ; _____ ; _____ ; _____ ;

I authorize Brotherton Counseling, LLC: **(MARK ALL THAT APPLY)** □ to release to □ to receive from

_____
(Name of agency, program, or individual) (city, state)

_____
(Name of agency, program, or individual) (city, state)

The items checked below from the mental health record / medical record of the above named client / client unit.
(Mark All that Apply)

_____ Assessment	_____ Diagnosis	_____ Psychosocial Evaluation
_____ Psychological Evaluation	_____ Psychiatric Evaluation	_____ Treatment Plan or Summary
_____ Current Treatment Update	_____ Medication Management	_____ Participation in Treatment
_____Nursing / Medical Information	_____ Educational Information	_____ Discharge/Transfer Summary
_____ Continuing Care Plan	_____ Progress in Treatment	_____ Demographic Information
_____Psychotherapy Notes*	_____ Other_____	_____ Other_____

(*Cannot be combined with any other disclosure)

It is understood that this information will be used for the purpose of... □ treatment / continuity of care □ other: _____ □ records are requested by client(s)/guardian(s) for his/her/their own use.

I understand that the treatment records may include medical, psychiatric, alcohol, and / or drug abuse information. I understand that my records are protected by law and cannot be disclosed without my / our joint consent. I understand that I am not required to authorize a release of confidential information in order to receive services. I understand that I may revoke this consent in writing at any time except for information that has already been sent. Unless I revoke it earlier, this consent will expire in □30 days, □60 days, □90 days, □120 days, □180 days, or automatically one year after the date entered below (date of signature).

SIGN HERE

_____
Signature of Client (age 18 or older) or Guardian (if < 18 years) *Printed Name of Client* *Date*

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