AUTHORIZATION TO RELEASE AND/OR EXCHANGE INFORMATION

This form, after I complete and sign, authorizes my counselor to release and/or exchange protected information from your clinical record to the person or organization I designate.

I_____(DOB _____) authorize my counselor,_____,
to release and/or exchange the following information: ☐ verbally ☐ written ☐ copy of records ☐ other:_____

☐ Intake/Assessment	☐ Psychological Testing/Evaluation	☐ Psychosocial History
☐ Treatment Goals/Status	☐ Recommendations	☐ Medical Status/Medications
☐ Consultations	☐ Other:_____	

This information should only be released to and/or exchanged with:

Name:_____ Phone/Fax:_____

Address:_____

City/State/ZIP:_____

_____I authorize the above named person to release and/or exchange protected information with my counselor.
(Initials)

I am requesting the release and/or exchange of this information for the following reason(s):

☐ Continuation or Coordination of Care	☐ Personal	☐ Other:_____
☐ Insurance	☐ Legal	

This authorization shall remain in effect until _____(requires a specific date).

I have the right to revoke this authorization, in writing, at any time by sending such written notification to Zion Restoration Counseling Services However, my revocation will not be effective to the extent that I have taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
I understand that my counselor generally may not condition counseling services upon my signing this authorization unless the counseling services are provided for the purpose of creating health information for a third party.

I understand I have the right to inspect the disclosed mental health information at any time.

_____ _____
Signature of Client Date

_____ _____ _____ _____
Parent/Guardian/Client Representative Date Signature of Witness Date

A copy of this form is available upon request.

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