STONE CITY COUNSELING, Inc.

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Authorization for Use/Disclosure of Protected Information

This form is to confirm your authorization to use/disclose your protected health information. This release of information is for the purpose of counseling and related treatment.

Client: _____ **DOB:** _____ **Date:** _____

Client Address: _____

If under 18 years old, Parent/guardian printed name: _____ DOB: _____

The purpose of this disclosure is to inform the above named agency(ies) of attendance and progress in treatment.

I hereby authorize Stone City Counseling, Inc.. to exchange the information indicated below, concerning the above named individual, with:

Agency and/or Person: _____ Address: _____

Phone: _____ Phone: _____ Fax: _____

____A. Psychosocial Assessment/Evaluation/Treatment Plan/Outpatient treatments/Treatment Summary

____B. Psychiatric Evaluations/Psychological testing results/Recommendations

____C. Information regarding Drug and/or Alcohol evaluation, assessment, diagnosis, treatment and treatment summary

____D. Medical/Physical Information including diagnosis/prognosis, medications, discharge summary/recommendations

____E. Academic/School Transcript/Achievement Test Scores

____F. Full and complete record (relevant information at staff discretion)

____G. Other (Specify): _____

I understand I may revoke this authorization at any time by giving my written notice and that no further records will be released except to the extent that release has been made prior to receipt of the revocation. I authorize the use of photocopy or facsimile of this form to be as valid as the original. I understand that my records are protected under state and federal confidentiality Statutes and/or regulations and that these records cannot be disclosed to anyone else without my written consent. I understand that this consent would normally expire by law after a period of 180 days; however, I expressly waive the 180 day limitation and consent to the disclosure and exchange of information as long as I am in treatment with Stone City Counseling, Inc. and/or requesting agency/ unless sooner if specifically revoked by me in writing. I understand that no treatment may be conditioned on whether I sign this authorization. I understand that I am entitled to a copy of this authorization.

Parent/guardian signature (if applicable): _____ Date: _____

Client signature: _____ Date: _____

Witness signature: _____ Date: _____