

WESTPORT COUNSELING & THERAPY
AUTHORIZATION TO RELEASE INFORMATION FORM
(45 CFR Parts 160 and 164 and 42 CFR Part 2)

Client Name: _____

Client Date of Birth: _____

Information is being released to: _____

Address: _____

Relationship to Patient:
 Spouse/Family Member
 Attorney/Probation Officer
 Physician
 Other: _____

Phone: _____

Fax: _____

Email: _____

Specific Information to be Disclosed (Check all areas which apply):

- | | |
|--|--|
| <input type="checkbox"/> Nature of the treatment program | <input type="checkbox"/> Whether client has relapsed into alcohol/drug use and the frequency of such relapse |
| <input type="checkbox"/> Presence in treatment and attendance | <input type="checkbox"/> Evaluation and assessment |
| <input type="checkbox"/> Client's progress in treatment | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Client's prognosis (likely course of problem) | |

Purpose for Releasing Information (Check all areas which apply):

- | | |
|--|--|
| <input type="checkbox"/> To facilitate understanding and support or treatment | <input type="checkbox"/> To communicate with judge/attorney |
| <input type="checkbox"/> To communicate with significant other/family member(s) to facilitate understanding and support of treatment | <input type="checkbox"/> To satisfy probation/parole requirements |
| <input type="checkbox"/> To assist with evaluation and treatment | <input type="checkbox"/> To assist or comply with legal situations or requirements |
| <input type="checkbox"/> For placement and referral purposes | <input type="checkbox"/> Other: _____

_____ |

I understand that my records are protected under the federal regulations governing the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, 45 CFR Parts 160 and 164, and Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically one year from the date of signature.

I here by authorize, Westport Counseling & Therapy to release the information stated above.

Client Signature

Date

Therapist Signature

Date

Prohibition on Redislosure Alcohol and Drug Abuse Information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from any further disclosures of it without the specific written consent of the person to who it pertains, or as otherwise permitted by such regulations. A general authorization or the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.