



Client Release of Information Form

CLIENT INFORMATION:

Client's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ DOB: _____

I, _____, am a therapy client with and authorize JRNY Counseling to meet with, send, receive, and share confidential information with:

Name: _____

Business: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

This agreement is in place:

From (today's date): _____ to (date 1 year from today): _____

(A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR
*PSYCHOTHERAPY NOTES.)

Purpose for disclosure:

- Presence in and/or discharge from treatment
- Planning appropriate treatment or program
- Continuing appropriate treatment or program
- Coordination of care with other providers
- Case review
- Medical consultation
- Legal consultation
- Determining eligibility for insurance benefits or program
- Other (specify): _____

I understand this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed about what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Client's Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

Witness (if client is unable to sign) Signature: _____