**The Other Road Counseling PLLC**

**Phone number 860-208-3396**

**Fax number: 855-217-8024**

Authorization for Release of Information (Protected Health Information)

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (Mailing) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize *The Other Road Counseling PLLC* to use and disclose information from my mental health record, which may include information about psychiatric diagnosis and treatment concerns to:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I wish to disclose the following information (please check):

|  |  |
| --- | --- |
| \_\_\_\_\_ Attendance and therapy sessions | \_\_\_\_\_ School |
| \_\_\_\_\_ Intake/Assessment | \_\_\_\_\_ Medical and Psychiatric Records |
| \_\_\_\_\_ Process of Therapy | \_\_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_ Medication Management |  |

1. I understand that, unless withdrawn by writing, this authorization will expire 180 days from the date of this signature. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying **The Other Road Counseling PLLC** at the email address provided, in writing, and this authorization will terminate to be effective on the date notified except to the extent action has already taken in support upon it.
3. I understand that information used or disclosed following this authorization may be subject to redisclosure by the recipient and no longer protected by /federal privacy regulations. However, other state or federal laws may not allow the recipient and disclosing specially protected information, such as substance abuse treatment information and mental health information.
4. I understand that I can request a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this authorization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of parent/guardian (if client is under the age of 18 years old) Date

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Clinician signature Date