Release of Protected Health Information

Client name:_____ Date of birth:_____

Address:_____

Phone number:_____

I give permission for Beckner Counseling to share/receive information to/from:

Person or Agency:_____

Address:_____

Phone number:_____

Fax/Email:_____

The following information regarding the client may be shared:

_____

_____

(Ex. Intake assessment, psychotherapy notes, treatment plan, discharge information)

For the purpose of:

_____

(Ex. Continuity of care, care-coordination)

I understand that I have the right to revoke this release of information at any time as long as the information has not already been released. Unless otherwise specified, this release of information will expire 1 week after discharge from Beckner Counseling.

I understand that the information that may be disclosed to the above person or agency may include, but is not limited to, substance use, abuse history, and mental health treatment

Client name:_____Date:_____

Parent/Legal Guardian:_____Date:_____