Amigo Family Counseling, LLC

355 E. Campus View Blvd., Suite 105, Columbus, OH 43235
(614) 310-1234 * (614) 310-1237 (fax)

Request/Authorization to Release Confidential Records and Information

I hereby authorize: Amigo Family Counseling, LLC to **Release to** (initial) ☐ **Obtain from** (initial) ☐

Person/Agency:____

Address:____________________________________ Phone: ______________

____________________________________ Fax: ______________

Information from records about __________________________ DOB:______________

for the following purpose(s):

- ☐ Further mental health evaluation, treatment, or care
- ☐ Treatment planning
- ☐ Coordination of Care
- ☐ Phone Consultation
- ☐ Billing
- ☐ Other: ________________________

These records concern the time between ____________________ **and** ____________________.

The information to be disclosed is marked by an X in the boxes below.

- ☐ Intake and discharge summaries
- ☐ Developmental and/or social history
- ☐ Treatment plans
- ☐ Psychological testing results
- ☐ Report of Teacher's Observations
- ☐ Medication Management Information
- ☐ Medical history & evaluations
- ☐ Academic/Educational records
- ☐ Progress Notes
- ☐ Achievement/other test Results
- ☐ Letter w/ Dates of Treatment & Progress Summary
- ☐ Mental Health Evaluations
- ☐ Closing Summary
- ☐ Psychiatric Evaluation
- ☐ Dates of service & charges
- ☐ Other: ____

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless initialed here: ______ **Do not release**

Revocation:

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Amigo Family Counseling, LLC. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration:

Unless sooner revoked this authorization will **expire one year from the date signed** or as otherwise indicated:

- ☐ Mutually agreed upon ending of treatment
- ☐ 90 days after last direct service contact
- ☐ Other indicator: ____

Form of Disclosure:

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

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Redisclosure:

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by such person or entity and may no longer be protected by the federal privacy regulations unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that my records/protected health information cannot be released unless I sign this form.

____ ______________________________
Signature of client Date

____
Printed name

____ ______________________________
Signature of parent/guardian/personal representative Relationship

____ ______________________________
Printed name Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.). ____

Please note: If you are a guardian or court appointed representative, you must attach a copy of your legal authorization to represent the client.

Witnessed by:

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent.

_____________________________________ _____________________________________ ______________
Signature of witness Printed name Date

Directions for Administrative Staff:

☐ Copy for patient or parent/guardian ☐ Copy for mail ☐ Copy for chart

* A photocopy of this release is considered equivalent to the original.

Prohibition on Redisclosure: This information has been disclosed from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information, if held by another party, is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be subject to prosecution under Federal law.