Counseling Connections
Release of Information Authorization

I, _____, _____
(Print Name) (Social Security Number)

Hereby give permission to: _____ to disclose the

Following information to: _____ in connection with my case.

□ Diagnostic Assessment
□ Treatment Plan
□ Progress Notes
□ Substance Abuse Evaluation
□ Treatment Recommendations
□ Expected length of treatment
□ Entire Record
□ Other: _____

The purpose for such disclosure is:

□ To provide continuity of care
□ To permit processing of a benefit claim
□ To enable my employer to make an employment status determination
□ Other _____

I may revoke this consent at any time except to the extent that action has been taken in reliance on it. If I do not revoke it, this consent will expire one year after the case is closed.

_____ _____
(Signature) (Signature of parent/guardian)

_____ _____
(Date) (Witness)

I understand that my records are protected under State confidentiality statutes and may be protected under Federal regulations (42 CFR, Part II) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. This authorization may be withdrawn at any time in writing except to the extent that the program or person which is to make this disclosure has acted in reliance on it. Authorization will remain in effect as agreed to above. Upon revocation of consent, further release of information shall cease immediately. File copy is equivalent to the original.