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Catalyst Counseling LLC

Request/Authorization to Release Confidential Records and Information

Your mental health records are protected under the Health Information Protection and Privacy Act. You choose to whom the information is released, the type of communication and you can provide special instructions.
Please state the reason for this release here in your own words, and then check the boxes below and/or give special instructions.

Name of client _____ Date of birth _____

Name of Guardian/Parent _____

This release is being requested for this reason:_____

_____

I hereby authorize: **Norma Vaillette LMHC**

to release information from records about (client name) _____,

for the following purpose(s):

- ❑ Further mental health evaluation, treatment, or care ❑ Continuity of care or services
- ❑ Treatment planning ❑ Research ❑ Consultation and Review
- ❑ Other: _____

_____

These records concern the time between _____ and _____.

In the boxes below, mark the information **to be disclosed**

- ❑ Intake and discharge summaries (onset and end of treatment)
- ❑ Treatment Review Report only, no notes
- ❑ Letter of therapy session attendance
- ❑ Verbal contact only
- ❑ Verbal and written communication
- ❑ Progress notes, and treatment or closing summary (full file)
- ❑ Progress letter only
- ❑ Other:_____

_____

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: ❑ Do not release HIV-related information ❑ Do not release drug and alcohol information.

Other instructions: _____

_____

I give permission to release records to: (1)_____

Address:

_____

_____

_____

Phone: _____ Fax: _____

And **to** (Person or facility): (2)_____

Address:

_____

_____

_____

Phone: _____ Fax: _____

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 likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after one year from the date on which it is signed, or upon fulfillment of the purposes stated above. The duration of this release goes from the date signed to this date _____ or 1yr If a date is not specified.

_____ _____ _____

Signature of client | Printed name | Date

_____ _____ _____ _____

Signature of parent/guardian/representative | Printed name | Relationship | Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

_____ _____ _____

Signature of witness Printed name Date

❑ Copy for patient or parent/guardian ❑ Copy for source of records ❑ Copy for recipient of records