

Release of Information Consent - Reciprocal

SKVenisonLMFT

Client's Name: _____

Address: _____ City: _____ State: _____
Zip: _____

Phone: _____ DOB: _____

Request to obtain information from:

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR PSYCHOTHERAPY NOTES.

- | | |
|------------------------------------|--------------------------------------|
| _____ Academic testing results | _____ Psychological testing results |
| _____ Behavior programs | _____ Service plans |
| _____ Progress reports | _____ Summary reports |
| _____ Intelligence testing results | _____ Vocational testing results |
| _____ Medical reports | _____ Entire record, except progress |
| _____ Psychotherapy notes | |
| _____ Psychological reports | _____ Others, specify |
| _____ | |

The above information will be used for the following purposes:

- _____ Planning appropriate treatment or program
 _____ Continuing appropriate treatment or program
 _____ Case review _____ Updating files
 _____ Other (specify)

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to client: _____ Self _____ Parent/legal guardian

_____ Legal representative _____ Other (describe) _____

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: _____ Date ____/____/____

Parent/guardians/personal representative (if applicable)

Signature: _____ Date ____/____/____

Witness (if client is unable to sign)

Signature: _____ Date ____/____/____