



AUTHORIZATION TO RELEASE INFORMATION

I authorize SAFE HARBOR CHRISTIAN COUNSELING to release to, and receive from

_____ (Name)

_____ (Address)

School System Hospital Private Clinician

Pediatrician Court System Other

Family Member/Support person

the following information on _____ (Patient Name) _____ (DOB)

- | | |
|---|---|
| _____ Medical Records | _____ Academic Records/Educational Evaluation |
| _____ Medical History/Physical | _____ Treatment Plan/Patient Progress |
| _____ Psychological Evaluation | _____ Discharge Summary |
| _____ Social History | _____ Special Education File |
| _____ Neurological Evaluation | _____ Immunization Records |
| _____ Results of Drug and Alcohol Treatment/Testing | _____ Other (Specify) _____ |

For the purpose of: _____

Approximate dates of service: _____

I have been informed of the type of information being released, the benefits and disadvantages (if any), and understand that treatment services are not contingent upon my decision concerning the signing of this release. I have also been informed that my photocopied signature is as valid as the original.

Signature of Patient: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

(If patient is a minor)

Signature of Witness: _____ Date: _____

Note: Remember to ask for permission to release information to any key person who has worked with the patient and family (i.e. probation officer, hospital clinician, private practice clinician, teacher, guidance counselor, attorney, etc.)

As required by Section 2.32(a) PROHIBITION ON DISCLOSURE –rule: “This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.”