# Believe Counseling Services

BELIEVE IN YOUR TRUTH

# RELEASE OF CONFIDENTIAL INFORMATION
# Consent & Authorization

Client Name:_____

I, (client or legal guardian name) _____ give my consent and authorize Believe Counseling Services, to release protected health information (PHI) to (name of agency/person & relationship)**: SELECT ONE PER FORM.**

☐ Other: _____ Relationship: _____

Protected health information will be used for the sole purpose of providing treatment, obtaining payment, and general health care operations.

I understand that information will be disclosed only for the purpose(s) noted above, and that the release of information will cover the following information:

- Psychiatric/Psychological/Social Assessment
- Treatment Plan / Review
- Progress Notes
- Communicable Diseases
- HIV/AIDS Information
- Test / Lab Results
- Biopsychosocial Assessment
- Case Staffing
- Discharge Plan
- Medications
- Substance Use Information

Other: _____

Dates of records: From: _____ To: _____ or, if no dates are specified, all dates will be released.

I understand that my medical record to be released may contain medical information pertaining to behavioral or mental health services, drug and/or alcohol diagnosis and treatment. I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). See Notice of Privacy Policies for more details.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action had been taken in reliance on it, and that in any event, this consent expires automatically three months after my discharge from Believe Counseling Services.

**I have been offered a copy of this form and I have:** ☐ **Accepted** ☐ **Declined**

| | | |
|---|---|---|
| Client name (print) | Client Signature | Date |
| Parent/legal guardian name (print) | Parent/guardian consenting for treatment | Date |
| Theresa DeArmond, LPC, NCC<br>BCS Staff Member Name (print) ❋ | BCS Staff Member Signature & Credentials | Date |

❋BCS Staff member signing has ensured that client/guardian understands the information included in this ROI.

**NOTICE TO RECIPIENT OF INFORMATION:** Federal regulations prohibit you from making any further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any drug or alcohol abuse client.