South SHORE
COUNSELING

Authorization To Release Information

Print Name_____ Maiden Name_____

SS#_____ DOB_____

I hereby authorize South Shore Counseling (circle one): to release to / to receive from

_____

(Name of agency program or individual)

_____

(Address)

The items checked below from the medical record of the client named above.

To Release (circle all that apply):

- Intake & Assessment findings
- Intake & Assessment findings
- Progress Notes
- Discharge Summary
- Treatment Plan
- Summary of Treatment
- Verbal Report
- Other_____

To Receive (circle all that apply):

- Intake and Assessment Findings
- Verbal Report
- Other_____

This information will be used for the purpose of_____ or ( ) at the request of the individual.

I understand that the treatment records may include my mental health information. I understand that my records are protected by law and cannot be disclosed without my consent. I understand that I am not required to authorize release of confidential information. I may revoke this consent, in writing, at any time, except for information that has already been sent. Information that is released is no longer protected by the privacy practices of South Shore Counseling. You have the right to see what healthcare information has been released. This release will be valid for ONE YEAR (max) from the date of signature, or ( ) specify a different length of time_____.

Client name_____Signature_____Date_____

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