Reflections Counseling
3320 E. Jefferson BLVD, South Bend IN 46615
Phone: 574.222.2466 Fax: 574.222.2468

Authorization for Release of Information

By Signing this Form I am Authorizing

_____
Clinician

to Disclose Protected Health Information to and/or Obtain Information from

_____
Name of Person/Organization who gets the records Phone # Fax #

Type of Information to be Disclosed:

☐ Treatment Progress Summary ☐ Psychological Testing Report
☐ Treatment Plan ☐ Presence/participation in treatment
☐ Complete Copy of Treatment Record ☐ Other: _____

This Authorization Remains in Effect for:

☐ 90 days ☐ 1 year ☐ other: _____

Purpose of Release:

☐ At the Request of the Client ☐ Continuity of Care ☐ Family Involvement
☐ Court Required ☐ Probation/Parole ☐ other: _____

I understand that I may revoke this authorization at any time by sending *written notice* to Reflections Counseling at the address listed above. Any information released prior to my cancellation, in compliance with this release, does not constitute a breach of confidentiality. Once information about you leaves this office, pursuant to this release, your information may no longer be protected under the HIPAA Privacy Rule, and this office has no control over how the recipient uses your information.

I understand that signing this release is voluntary and my refusal to sign would not affect my ability to receive services. I understand that this authorization may need to be obtained as a condition of obtaining insurance coverage for psychological services, or for the purpose of creating health information for a third party.

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Federal regulations restrict any use of the information to criminally investigate or prosecute drug or alcohol use.

I understand that if I can review the disclosed information or ask questions by contacting my therapist or Reflections Counseling.

Name of Client Date of Birth

Signature of: Client ☐ or Parent/Guardian ☐ Date