PARSONS COUNSELING & PLAY THERAPY CENTER

DETAILED RELEASE OF INFORMATION

Client Name: _____ DOB: _____

Social Security #: _____ Phone: _____

Address: _____

(street) (city) (state) (zip)

I, _____ ☐ self ☐ legal guardian/parent, hereby authorize Parsons Counseling, LLC. to:

☐ disclose Information to ☐ receive information from ☐ exchange information with

Name(s): _____ Phone: _____

Business Name: _____

Address: _____

(street) (city) (state) (zip)

The Information to be disclosed and/or received is:

- ❑ Attendance, behavior, and academic information
- ❑ Physician and medication update
- ❑ Any treatment records except client note
- ❑ Labs
- ❑ Other (specify) _____
- ❑ Summary of treatment progress verbal or written
- ❑ Progress in counseling and/or TCM services
- ❑ All treatment records

The purpose of this disclosure is for:

- ❑ Further Treatment
- ❑ Continuity of care
- ❑ Billing or Insurance
- ❑ Other (specify)_____

****This consent is effective for <u>one year</u> from the date signed below or until _____.****

I understand that I may revoke this consent at any time by giving written notice to the person or organization making this disclosure.

_____ _____

Client or Legal Guardian of Client Signature **Date**

_____ _____

Witness Signature **Date**

PROHIBITION ON REDISCLOSURE: According to 45 CFR 164.508 health information may be redisclosed by the recipient. However, pursuant to KRS 304.17a-555, *Patient's Right of Privacy Regarding Mental Health or Chemical Dependency - Authorized Disclosure* mental health/ chemical dependency info may not be used and/or shared by the recipient of said information unless specific, written consent for redisclosure is authorized by the person to whom it pertains. Additionally, Federal Regulations 42 CFR, Part 2 prohibits any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by law. 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 alcohol or drug abuse patient.

******I wish to revoke the above authorization******

_____ _____

Signature **Date**