Beach Counseling Services

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Release of Information

OPTIONAL (Required for Communication with Physician, Attorney, School, or Family Member for Patients Over the Age of 18.)

<u>SEND / REQUEST</u> RECORDS (Circle One or Discuss with your Clinician)

Client's Name _____Date of Birth: _____

Send / Request Records to:

_____
(Agency, physician, other (list)

Phone, Fax, and Mailing Address of this Agency: _____

Nature of information to be released (Please mark or initial):

_____ YES _____ NO Verbal IN ORDER TO DISCUSS DIAGNOSTICS, TREATMENT MODALITIES, ETC WITH ANY PARTY YOU PERMIT ABOVE-PHYSICIAN, ATTORNEY, FAMILY MEMBER

_____ YES _____ NO To obtain reports from releasing agency so the therapist can use this information for diagnosis and treatment.

_____ YES _____ NO To allow therapist to send reports to the above named agency. REQUIRED IN ORDER TO RELEASE RECORDS TO YOUR PHYSICIAN.

_____ YES _____ NO Other:_____ IF ADDITIONAL DETAILS/LIMITATIONS OF PERMISSION ARE REQUESTED, PLEASE DESCRIBE HERE

I hereby consent to the use or disclosure of my protected health information as specified above. I understand that this consent is voluntary and I may refuse to sign it. I understand that I may revoke this consent at any time by giving written communication to my provider or any member of the office staff. A revocation will not affect any action taken in reliance on the consent prior to the revocation. Other limitations on my right to revoke this consent may be found in my provider's Notice of Privacy Practices. I understand that if the recipient is not a health care provider or a health plan, the information disclosed under this consent may no longer be protected by federal privacy regulations and may be re-disclosed by the recipient. I understand that I should receive a copy of this consent, even if I do not ask for it.

I understand that treatment may not be denied if I refuse to sign this consent, except: (1) if the consent is the very reason for seeking health care (e.g., a pre-employment physical), that the health care may be denied, or (2) if the consent is for disclosure to a research study, I may be denied the treatment that is part of the study. In addition, the following consequences might occur: (1) if the consent is to demonstrate to a health plan that a service should be paid for, the health plan may refuse to pay for it, and (2) if the consent is sought by an insurer because I am seeking enrollment or eligibility, the insurer may deny me the coverage that I am seeking. I understand that a health plan may not refuse payment or benefits if I refuse to consent to disclosure of certain psychotherapy notes.

Expiration:

Unless sooner revoked by me, this authorization expires:

_____ YES _____ NO ONE (1) YEAR AFTER MY FINAL THERAPY SESSION WITH THE ABOVE NAMED THERAPIST.

_____ Other Time Limitation (Please specify) _____

_____ _____

Client Signature & Date Witness Signature & Date