Counseling Associates, LLC

Authorization For Disclosure of Client Information

Client Name: ____________________ DOB: ____________________
Herby Authorizes: Counseling Associates, LLC
Address: 111 Market Street, Suite 4A City, State, Zip: Winona, MN 55987
Phone: 507-452-5033 Fax: 507-452-5183 Email: ____________________

To: ☐ Receive From ☐ Release To ☐ Exchange With

Name of Person/Facility Receiving the Request: ____________________

Address: ____________________ City, State, Zip: ____________________

Phone: ____________________ Fax: ____________________ Email:____________________

Information Requested:
☐Complete Health Record(s)
☐Discharge Summary
☐Progress Notes/Case Notes
☐Prescriptions
☐Other (specify):

☐Client History
☐Consultation Reports
☐Diagnostic Assessment
☐Specific to SUD

I understand that this will include information relating to:
☐Behavioral Health Service/Psychiatric Care
☐Developmental Disabilities
☐Treatment for Substance Use Disorder(s)
☐Comprehensive Assessment for SUD

Covering The Time Period(s): from: ____________________ to: ____________________

For the purpose of:
☐ Further Health Care
☐ Application for Insurance
☐ Legal Investigation
☐ Personal
☐Changing Therapist
☐ Other (specify):

Your Rights with Respect to this Authorization:
-Right to Inspect of Copy the Health Information to be Used or Disclosed
-Right to Receive a Copy of This Authorization
-Right to Refuse to Sign this Authorization – I understand I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment enrollment in a health plan, or eligibility for healthcare benefits on my decision to sign this authorization. Information may be subject to redisclosure and no longer protected by the regulations.

I understand this authorization may be revoked in writing at any time. This authorization will expire **one year** from the date of my signature or otherwise designated date of _______. If I elect to revoke this authorization prior to its annual renewal date, or the designated date I selected, I understand that Counseling Associates, LLC cannot be held responsible for any records already released prior to writer notification, to the appropriate employee, that I am revoking my consent.

The facility, its employees, psychiatrists, and therapists are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. By signing this authorization, I am confirming it accurately reflects my wishes.

Your signature to disclose this information allows Counseling Associates, LLC to release your information by means of postal courier, faxes, and encrypted secure mail.

Signed: ____________________ Date: ____________________

Client is: ☐A Minor ☐Incompetent ☐Disabled ☐Deceased ☐Legal Authority ☐Custodial Parent
☐Legal Guardian ☐Power of Attorney ☐Legal Authorized Representative ☐Executor of Estate of Deceased