Aspire Counseling
302 Campusview Dr
Suite 202
Columbia Missouri 65201
5733282288

0. Release of Information and/or Records Request

Client name:

Date of birth:

Address (street, city, state, zip):

I hereby authorize:

Aspire Counseling and my therapist:

AND (name):

Their address:

Phone number:

Fax number (if applicable):

Relationship to client:

TO DISCLOSE TO AND COMMUNICATE TO ONE ANOTHER information contained in my patient/student records, including if any, alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Par 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA); social services records; psychological services records, including communications made by me to a social worker or psychologist; and all information defined by statute and Michigan Department of Public Health Rules (Public Act 174, 1989) governing Human Immunodeficiency Virus (HIV), HIV Test, Acquired Immunodeficiency Syndrome (AIDS), and AIDS-

related complex (ARC), only under very specific circumstances.

Specific Information to be Disclosed:

- ☐ ASSESSMENT
- ☐ COMMUNICATION EXCHANGE (email, contact log, text messages, etc)
- ☐ PROGRESS NOTES (a separate request must be made for psychotherapy notes)
- ☐ TREATMENT PLAN/CONTRACT
- ☐ DIAGNOSIS
- ☐ ADMISSION/DISCHARGE DATE
- ☐ SCHOOL/WORK RECORDS
- ☐ BILLING RECORD
- ☐ APPOINTMENT LIST
- ☐ DISCHARGE SUMMARY
- ☐ SUMMARY OF TREATMENT

OTHER PERTINENT INFORMATION (Specify):

PURPOSE AND NEED FOR SUCH DISCLOSURE

- ☐ CONTINUITY OF CARE
- ☐ SCHOOL/WORK COORDINATION
- ☐ REFERRAL FOLLOW-UP
- ☐ ARRANGE PAYMENT
- ☐ UPDATE/EDUCATE SUPPORT SYSTEM
- ☐ LITIGATION
- ☐ CHILDREN'S DIVISION/JUVENILE OFFICE COOPERATION
- ☐ RETURN TO SCHOOL/WORK

OTHER (Specify):

If readily available, I would prefer my information be disclosed

☐ Verbally (over the phone or in person)

☐ A physical, paper copy

☐ Electronically

I understand that my medical record may contain reports, test results and notes that only a care provider can interpret. I understand and have been advised that I should contact my care provider regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record. I will not hold Aspire Counseling or counselors liable for any misinterpretation of the information in my medical record as a result of not having consulted my care provider for the correct interpretation. I understand that generally my treatment may not be conditioned on whether or not I sign an authorization form, but that in certain limited circumstances I may be denied treatment if I do not sign an authorization form. This authorization is subject to a written revocation at any time except in those circumstances in which the counseling center has taken certain actions in reliance on such authorization. However, this authorization shall be valid no longer than is reasonably necessary to accomplish the purpose of the actions for which it was given. This authorization will automatically expire 12 months from the end of involvement in our programs or as specified in the revocation below.

Signature:

Date:

☐ Client is a minor or incapable of signing. A copy of the appropriate legal documentation is attached or has otherwise been provided to the practice if applicable. If I have joint custody, I have discussed this matter with any other legal guardian(s).

Relationship of signer to client (if applicable)::

REVOCATION (optional)

This authorization can be revoked at anytime for any reason by e-mailing info@aspirecounselingmo.com and requesting revocation.