Aspire Counseling

Healing | trauma | grief | fear | stress

Release of Information

2012 Cherry Hill Dr; Suite 202B; Columbia, MO 65203
p. 573-328-2288 e jtappanalcsw@gmail.com

Client Name:_____ Date of Birth_____
Address (street, city, state, zip) _____

I hereby authorize: Aspire Counseling and my therapist _____ **And**
Name _____
Address _____
Phone_____ Fax_____
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 the conditions listed below:

SPECIFIC INFORMATION TO BE DISCLOSED

☐ ASSESSMENT/DIAGNOSIS	☐ PROGRESS REPORTS	☐ REAUTHORIZATION FORMS
☐ COMMUNICATION EXCHANGE	☐ RECOVERY PLAN	☐ OTHER PERTINENT INFORMATION (Specify)_____
☐ PSYCHOSOCIAL/COUNSELING	☐ DISCHARGE SUMMARY	_____
☐ TREATMENT PLAN/CONTRACT	☐ DR. DISCHARGE SUMMARY	_____
☐ LAB RESULTS	☐ _____	_____
☐ ADMISSION/DISCHARGE DATA SET	☐ _____	_____
☐ SCHOOL/WORK RECORDS	☐ _____	
☐ RELEVANT TO EDUCATION/WORK	☐ _____	Dates of Service_____

PURPOSE AND NEED FOR SUCH DISCLOSURE

☐ CONTINUITY OF CARE	☐ _____	☐ RETURN TO SCHOOL/WORK
☐ SCHOOL/WORK COORDINATION	☐ _____	☐ OTHER (Specify)_____
☐ REFERRAL FOLLOW-UP	☐ _____	_____
☐ FAMILY NOTIFICATION		

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 Witness
Date

Relationship of signer to client (if applicable) ☐ Client is a minor or incapable of signing. A copy of the appropriate legal documentation is attached if applicable. If I have joint custody, I have discussed this matter with the other legal guardian(s).

_____

☐ **DRIVERS LICENSE/IDENTIFICATION VERIFIED**

REVOCATION (optional) – This authorization is revoked for the following specified dates, events, or conditions.

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Date:_____Event:_____ Condition:_____