Haley Weiss, M.A., NCC
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RELEASE OF INFORMATION

Client Name: _____ Date of Birth: _____

I, _____, hereby authorize Haley Weiss Counseling, LLC to:

- ❏ disclose information to
- ❏ receive information from
- ❏ exchange information with

Name or Agency Name: _____

Address: _____

Email: _____ Phone: _____

Relationship to client:

- ❏ Self
- ❏ Parent/Legal Guardian
- ❏ Other (please specify): _____

In accordance with Federal Register Vol. 65, Part II, Subpart E 164.508, I authorize Haley Weiss Counseling, LLC to disclose my protected health information (PHI) for the purpose of:

- ❏ Medical Follow-up
- ❏ Continuing Treatment
- ❏ Admission, Continued Stay, and Discharge Communication
- ❏ Funding/Eligibility Verification
- ❏ Psychiatric Evaluation
- ❏ Family Involvement
- ❏ Emergency Contact
- ❏ Other (please specify): _____

The health information to be released is limited to the following:

- ❏ Psychosocial/Assessment/Evaluation
- ❏ Treatment Plans
- ❏ Treatment Progress Reports
- ❏ Progress Notes
- ❏ Assessment/Testing Information
- ❏ Discharge Summary
- ❏ Aftercare Plans/Recommendations
- ❏ General Progress Update
- ❏ Verification of Presence in Treatment
- ❏ Other (please specify): _____

The above information will be used for the following purposes:

- ❏ Planning appropriate treatment or program
- ❏ Continuing appropriate treatment or program
- ❏ Determining eligibility for benefits or program
- ❏ Case review
- ❏ Updating files
- ❏ Other (please specify): _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

This authorization shall remain valid until: _____ (not to exceed one year)

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client Signature: _____ Date: _____

Client Name: _____

Witness Signature (if client is unable to sign): _____ Date: _____

Witness Name: _____