Phoenix
COUNSELING SERVICES, LLC

Client Name: _____ DOB:_____

Authorization for Release of Information

I, _____ do hereby consent to authorize Phoenix Counseling Services, LLC to receive from _____ information from my record(s). The specific information to be received includes:

__ Admission
__ Attendance in Treatment
__ Prognosis/Diagnosis/ Treatment Recommendations
__ Summary of Treatment
__ Patient Data Form
__ Discharge Summary
__ Progress Notes
__ Treatment Plans
__ Aftercare Plans
__ Initial Evaluation
__ Psychiatric/Psychological Evaluation
__ Medical History
__ Medication Management
__ Prescription Medications
__ Other: _____

I, _____ do hereby consent to authorize Phoenix Counseling Services, LLC to receive from _____ information from my record(s). The specific information to be received includes:

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__ Initial Evaluation
__ Psychiatric/Psychological Evaluation
__ Medical History
__ Medication Management
__ Prescription Medications
__ Other: _____

I understand that the information is to be used for the purpose of _____

This information is being disclosed from records whose confidentiality may be protected by Pennsylvania Law, Act 63, and/or Pennsylvania P.L. 817, and/or Federal Law 93-282, and/or Federal Regulations, 42 (Drug and Alcohol treatment records). I understand that I have the right to request to inspect materials that shall be released. I understand that I may revoke this authorization at any time by notifying my counselor verbally or in writing. This Authorization shall expire six months after discharge unless an earlier date is specified.

If the client is not in treatment at the time of signing, this authorization will expire three months after signing.

Authorization REVOKED on _____ (Date) at _____ (Time) AM/PM

Staff signature: _____

Signature:

X_____ _____
___ Patient ___ Parent ___Guardian ___Power of Attorney — Date

_____ _____
Signature of Witness — Date

Client has accepted or Rejected a copy of this document

Updated on 7/11/17
Phoenix Counseling Services, LLC