

Authorization to Release Information

To facilitate informed services, I _____ (DOB: _____)
hereby authorize the mutual release/exchange of information concerning:

- | | |
|--|-----------------------------|
| _____ Information Regarding Previous Treatment | _____ Progress in Treatment |
| _____ Medical Information | _____ Evaluation Results |
| _____ Mental Health Information | _____ Other: _____ |
-

between **Inari Counseling** and

Person: _____

Organization: _____

Address: _____

Phone: _____ Fax: _____

I understand that records containing information about the diagnosis, treatment, or referral of alcohol and drug abuse problems are protected under federal confidentiality regulations (42 CFR, Part 2 – Alcohol and Drug) and cannot be disclosed without my written consent. I also consent to the release of that information. _____ (client initial)

I understand that my records may contain information regarding testing, diagnosis, or treatment of HIV/AIDS, or sexually transmitted diseases. I consent to the release of that information. _____ (client initial)

Other parties receiving this information are prohibited from re-disclosing these records, unless expressly permitted by my written consent, unless disclosure is otherwise permitted by federal regulations.

This consent will expire upon the completion of treatment or any other agreed upon date.

Client signature: _____ Date: _____