Denouement Counseling
336.365.6626
1107 West Market Street
Greensboro, NC 27403

Authorized Release of Mental Health Information
Effective from _____ to _____.

Client's name (printed) _____, DOB, _____,

I authorize Mary Roberts, LPC, LCASA, to _____ exchange, _____ receive, _____give, information with:
Name/organization _____Phone #
Address _____ Fax #

Regarding: ___ Myself or _____ My minor child: _____Name
_____DOB

Information to be released:

_____ All of the following
_____Scheduling/attendance
____Treatment plans and goals
____Payment information
____Diagnosis/assessment results
____Treatment summary/progress notes
____Response to treatment
____Other:

Information is being released for the purpose of:

___ Facilitation of payment
___Collaboration/consolation
___ Personal use
___Facilitation of continuity of care
____ Facilitation of scheduling/transportation
____Facilitation of family involvement in treatment
___ Legal purposes
____ Other:

I understand this authorization is subject to revocation at any time, except to the extent that action has been taken in reliance on the authorization.

I understand that my health information is protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 that re-disclosure is prohibited, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by the HIPAA Privacy Law.

This form has been fully explained and I certify that I understand its contents. I understand that; Denouement Counseling/Mary Roberts, LPC, LCASA; may not condition treatment on obtaining this consent/authorization from me.

Client's name printed _____ Date
Client's signature_____Date
Parent/guardian's name printed _____ Date
Parent/guardian's signature _____ Date
Counselor's signature _____ Date