



# Gold Circle Counseling LLC

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## Release of Confidential Information (Protected Health Information)

Regarding: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Client's Name (print or type)

Address: \_\_\_\_\_

I authorize \_\_\_\_\_ to  
(Behavioral health provider)

\_\_\_\_\_ Release information to: \_\_\_\_\_ Receive information from: \_\_\_\_\_ Exchange information with:

\_\_\_\_\_ Name and Identifying Relationship to client (ex. teacher, physician, mother) \_\_\_\_\_ Phone

\_\_\_\_\_ Address \_\_\_\_\_ Fax Number

My signature indicates that I understand my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations and/or under state specific provisions. I authorize the release/exchange of the following information (check all that applies):

- |   |   |
|---|---|
| <input type="checkbox"/> Diagnosis, Progress, Prognosis             | <input type="checkbox"/> Joint session                            |
| <input type="checkbox"/> Admission & Discharge summary              | <input type="checkbox"/> Progress Notes Treatment Recommendations |
| <input type="checkbox"/> Medications Past/Current & Recommendations | <input type="checkbox"/> Treatment summary                        |
| <input type="checkbox"/> Attendance in Treatment                    | <input type="checkbox"/> HIV/AIDS                                 |
| <input type="checkbox"/> Psychiatric Evaluation                     | <input type="checkbox"/> Other: _____                             |
| <input type="checkbox"/> Alcohol/Substance Assessment               |   |

The reason for releasing this information is:  
 Coordination of care  At the request of the client  Other: \_\_\_\_\_

**This authorization will expire 1 year from the date of signature below unless revoked prior to that date:**

- You may revoke this authorization at any time by notifying the above behavioral health provider at Gold Circle Counseling, LLC in writing. However, revoking this authorization in writing will not affect any actions taken before receipt of that notice.
- The information disclosed based on your signed authorization may be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws.
- You do not need to sign this form in order to obtain services from Gold Circle Counseling, LLC.
- This authorization is completely voluntary, and you do not have to agree to authorize any disclosure.
- You have a right to a copy of this authorization once you have signed it.

\_\_\_\_\_  
Signature of Client/or Parent if Minor/Guardian

\_\_\_\_\_  
Date Signed

**Notice To Recipient of Information:**

This information has been disclosed to you from records which may be protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.