DARREN W. LOVE, M.ED.
Therapy | Speaking | Coaching

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# Consent to Release/Obtain Information

*** Please Note Highlighted Section

Client Name (first, middle initial, last) _____

Date of Birth _____ Social Security # _____

**In accordance with Federal Regulation 42 CFR, Part 2, I hereby authorize:**

Name of individual or institution _____

Address _____
City State & zip code

**For the following information (list specific report or types of information)**

_____ Discharge Summary _____ Progress Notes _____ Diagnostic Assessment
_____ Psychiatric Evaluation _____ Psychosocial History _____ Treatment Plan
_____ Other (specify) _____

**for dates of services including** _____ **to** _____

**This includes psychiatric records related to emotional illness and information regulated by Federal Public Law 930-282; confidentiality of alcohol and drug abuse patients. Also included are records documenting the diagnosis and/or treatment of AIDS, ARC, HIV positive, and other related diseases.**

_____ **Initial *****

*"This information has been disclosed to you from records protected by Federal Confidentiality Rules. The Federal Rules prohibit you from making any further disclosures of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R., Part 2. A general authorization for release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client."*

**Purpose for disclosure: for the specific purpose of (check one or more)**

____ Comprehensive Treatment ____ Family Involvement ____ Aftercare/follow-up
____ Legal Issues Other: _____ (OVER)

This authorization for release of information will automatically expire ninety days after the date of the authorization unless I expect to continue receiving services beyond ninety (90) days and extend the authorization to a maximum of one hundred eighty (180) days.

Expiration date is _____

Condition, date, or event of earlier or later expiration _____

Name and Signature of Staff Facilitating this request Darren W. Love, M.Ed., LPCC-S

_____

I understand that this release can be revoked by me at any time. The revocation must be signed and dated by me unless I am receiving substance abuse services and therefore may verbally revoke consent. Upon revocation of consent, further release of information shall cease immediately.

_____ _____
Date Signature

_____ _____
Witness Relationship

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**I hereby REVOKE my consent for release of the above information**

_____ _____
Date Signature

_____ _____
Witness Relationship

_____ _____ _____
Date of Verbal Revocation Staff Signature Date

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Notation of Records Sent _____

_____ _____
Signature Date