AUTHORIZATION TO RELEASE INFORMATION

I authorize Higgins Counseling Services to release to, and receive from:
Name _____ Phone: _____
Address_____
_____

[ ] School System [ ] Hospital [ ] Private Clinician
[ ] Pediatrician [ ] Court System [ ] Other
[ ] Family Member/Support person
The following information on _____
_____

Patient Name:_____ DOB:_____

_____ Medical Records
_____ Medical History/Physical
_____ Psychological Evaluation
_____ Social History
_____ Neurological Evaluation
_____ Academic Records/Educational Evaluation
_____ Treatment Plan/Patient Progress
_____ Discharge Summary
_____ Special Education File
_____ Results of Drug/Alcohol Treatment/Testing

Other (Specify):
_____

For the purpose of:
_____

Referral question (if applicable):
_____
_____
_____

Approximate dates of service:
_____

Name of Counselor:_____ Cell Phone: _____

I have been informed of the type of information being released, the benefits and disadvantages (if any), and understand that treatment services are not contingent upon my decision concerning the signing of this release. I have also been informed that my photocopied signature is as valid as the original.

Signature of Patient: _____ Date: _____

Signature of Custodial Parent/Guardian: _____ Date: _____

(Patient is a minor)

Signature of Witness: _____ Date: _____

Note: Remember to ask for permission to release information to any key person who has worked with the patient and family (e.g., probation officer, hospital clinician, private practice clinician, teacher, guidance counselor, attorney, etc.)
This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.