Client Release of Information

Authorization for use/disclosure of information:

I voluntarily consent to authorize **Blue Sky Counseling Associates** to use or disclose information pertaining to services I received at their facility with the recipients I have identified below.

Recipient:

I authorize **Blue Sky Counseling Associates** to release my information to the following recipients:

Name: _____

Address: _____

Phone: _____

Purpose:

I authorize my information to be released for the purposes of: _____

_____

Information to be disclosed:

☐ Progress Notes

☐ Intake Information

☐ Contact Information

☐ Only the following information: _____

_____

Term:

I understand that this release will be in effect from:

☐ (date): _____ to (date): _____

☐ Until the provider fulfills the request

I understand that my records are protected under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 CFR, Parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time and that any notice to revoke consent must be in writing.

Print Name: (Parent/Guardian if under the age of 18) _____

Signature: _____