Authorization for Release of Information

This form when completed and signed authorizes the release and/or exchange of protected information from your clinical record to the person(s) designated.

I ___________________________ Date of Birth ____________ authorize Trellis Counseling, LLC to release and/or exchange the following types of information:

	Initial Assessment		Treatment Plan		Consultation Reports
	Case Notes		Psychological Testing and Evaluations		Educational Assessments
	Chemical dependency Evaluation				
	Other (Specify):				

I am authorizing the release of this information for the following reasons:

	Background information/Assessment		Coordination of Care
	Other (Specify):		

This information will be released and/or exchanged with:

Individual and Clinic Name	
Address	
Phone/Fax	

This authorization will expire:

	Immediately after requested information is received		30 days after termination of treatment
	Other (Specify):		

You have the right to revoke this authorization, in writing, to Trellis Counseling at anytime. However, your revocations will not be effective on action already taken in reliance of this authorization or, if this authorization was obtained as a condition of obtaining insurance coverage, to which the insurer has a legal right to consent a claim. Your therapist may not, in general, condition the providing of psychological services upon your signing an authorization unless the psychological services are being provided to you for the purpose of creating health information for a third party. The information disclosed pursuant to this authorization may be subjected to redisclosure by the recipient of your information and no longer protected by the HIPAA privacy rule. If this authorization is signed by a personal representative of the client, a description of such representative's authority to act on behalf of the client must be provided.

_____________________________ __________
Client's Signature Date