

Assurance Counseling Services LLC – 2301 Graham Avenue, Windber, PA 15963

Office: 814.467.4567 ext 820

Consent for Release of Information Form

I, _____ (parent/guardian) of _____

DOB: _____ hereby authorize Assurance Counseling Services LLC to: ___ send ___ receive, the following, ___ to ___ from the following agency or person:

Agency Name Address Phone Fax

For treatment and/or services from _____ to _____.

Information/Documents Requested

___ Academic testing ___ Behavior programs ___ Case notes/Therapy notes
___ Intelligence testing ___ Medical reports ___ Progress reports
___ Psychological reports ___ Entire record ___ Psychological Evaluations
___ Verbal communication ___ Email Communication ___ Other: _____

Purpose

The above information will be used for the follow:

___ Planning appropriate treatment or program ___ Determining eligibility for benefit
___ Continuing appropriate treatment or program ___ Case review
___ Other (specify) _____ ___ Updating files

Signature(s):

"I, understand that I may revoke this consent at any time by providing written notice to the office address listed above. However, this revocation will not be effective to the extent that action was taken by Assurance Counseling Services LLC in reliance on the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to consent a claim. After one year this consent automatically expires. I understand that my psychologist/psychiatrist/therapist generally may not condition therapeutic services upon my signing an authorization unless the therapeutic services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule. I have been informed what information will be given, its purpose, and who will receive the information.

This consent to Release Information is valid from _____ to _____.

Client Date Parent/Guardian (if needed) Date

Witness Date Person informed client of their rights Date

___ Unable to sign therefore giving verbal consent to release information _____
(person giving verbal consent)

Witness Date Witness Date

