

## Release of Information Consent

Client's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

I: \_\_\_\_\_ authorize Venus Rouhani to: (send) (receive)

The following Summary of the duration and treatment provided, and to collaborate with

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR \*PSYCHOTHERAPY NOTES.

Academic testing results

Psychological testing results

Behavior programs

Service plans

Progress reports

Summary reports

Intelligence testing results

Vocational testing results

Medical reports

Entire record, except progress notes

Personality profiles

\*Psychotherapy Notes

Psychological reports

Other, specify: \_\_\_\_\_

The above information will be used for the following

Continuing appropriate treatment or program

Determining eligibility for benefits or program

Case review

Updating files

Other, specify \_\_\_\_\_

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a healthcare provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and in the state of Texas after) this consent automatically expires in 6 months. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to client:    Self    Parent/legal    guardian    Personal representative

Other: describe: \_\_\_\_\_

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

**I understand that by either placing my signature or typing my name, I am electronically signing this document.**

Name (Printed):

Signature:

Date: