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
- ☐ Behavior programs
- ☐ Progress reports
- ☐ Intelligence testing results
- ☐ Medical reports
- ☐ Personality profiles
- ☐ Psychological reports
- ☐ Psychological testing results
- ☐ Service plans
- ☐ Summary reports
- ☐ Vocational testing results
- ☐ Entire record, except progress notes
- ☐ *Psychotherapy Notes
- ☐ 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.

Full Name(Typed):

****** To sign this document, either type your full name or digitally sign below. ******

Signature: Date:

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