AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION/ RECORDS

I, client or parent/guardian of client _____ **Client's DOB:**_____

__hereby give my permission to **Choices Counseling and Advocacy Center, LLC** to release or request information within in my medical records from a third-party. This information may be released requested to _____ (name of person/ organization) for the purposes of _____.

____(initial) I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent.
____(initial) I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in federal law.
____(initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and presenting my written revocation to **Choices Counseling and Advocacy Center, LLC**.
____(initial) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and **Choices Counseling and Advocacy Center, LLC** will not base my treatment or payment whether or not I provide authorization for the requested use or disclosure. I understand that I may inspect or copy the information to be disclosed, as provided in CFR164.524 (with reasonable charge).
____(initial) I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or **Choices Counseling and Advocacy Center, LLC.** Choices Counseling and Advocacy Center, LLC will not be held liable for information disclosed to another party per the client's request.
____(initial) I understand that **Choices Counseling and Advocacy Center, LLC** will release only the minimum amount of information necessary to fulfill a request.

This authorization shall expire when the client is discharged from the current episode of care (treatment has been completed, the client rejects/declines/drops out of treatment, is referred elsewhere, moves, or in the case of the client's death.) This agreement is subject to revocation in writing at any time.

The type of information to be disclosed/requested is as follows (Please check the appropriate options):

To Be Released * *from* ***Choices Counseling***

____Treatment Plans
____Process Notes
____Health/Medical Records (if applicable)
____Letter(s) of Progress
____Bio Psychosocial Evaluation/Assessment (if applicable)
____ Verbal Communication
____Other (Specify): _____

To Be Requested * *from third parties*

____Treatment Plans
____Process Notes
____Health/Medical/Academic Records
____Psychological/Psychiatric Evaluations/Assessments
____Court Documents
____Verbal Communication
____Other (Specify): _____

Release:

_____

Client/ Guardian Signature and Date

Request:

_____

Client/ Guardian Signature and Date

111A Library Hill Lane Lexington, SC, 29072

Ph- (803)851-4049 Fax- (803)785-4948