COUNSELINGWORKS

ADOLESCENT · ADULT · COUPLES

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intake@counselingworks.com * (630) 281-2496

Client Name:_____ Date of Birth_____

Address (street, city, state, zip)_____

I hereby authorize: My therapist _____ _____

And Name_____

Address_____

Phone_____ Fax_____

Relationship to Client _____

TO DISCLOSE TO AND COMMUNICATE TO ONE ANOTHER information contained in my patient/student records, including if any, alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Par 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA); social services records; psychological services records, including communications made by me to a psychiatrist or psychologist.

SPECIFIC INFORMATION TO BE DISCLOSED		
☐ ASSESSMENT/DIAGNOSIS	☐ PROGRESS REPORTS	☐ REAUTHORIZATION FORMS
☐ COMMUNICATION EXCHANGE	☐ RECOVERY PLAN	☐ OTHER PERTINENT INFORMATION (Specify)
☐ PSYCHOSOCIAL/COUNSELING	☐ DISCHARGE SUMMARY	_____
☐ TREATMENT PLAN/CONTRACT	☐ DR. DISCHARGE SUMMARY	_____
☐ ADMISSION/DISCHARGE DATA SET	☐ _____	_____
☐ SCHOOL/WORK RECORDS	☐ _____	_____
☐ SCHOOL/WORK SOCIAL INVOLVEMENT	☐ _____	Dates of Service_____
	☐ _____	

PURPOSE AND NEED FOR SUCH DISCLOSURE		
☐ CONTINUATION OF CARE	☐ _____	☐ RETURN TO SCHOOL/WORK
☐ SCHOOL/WORK	☐ _____	☐ OTHER (Specify)_____
☐ REFERRAL FOLLOW-UP	☐ _____	_____
☐ FAMILY NOTIFICATION	☐ _____	_____

I understand that my medical record may contain reports, test results and notes that only a care provider can interpret. I understand and have been advised that I should contact my care provider regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record. I will not hold Counseling Works, or psychologists liable for any misinterpretation of the information in my medical record as a result of not having consulted my care provider for the correct interpretation. I understand that generally my treatment may not be conditioned on whether or not I sign an authorization form, but that in certain limited circumstances I may be denied treatment if I do not sign an authorization form. This authorization is subject to a written revocation at any time except in those circumstances in which Counseling Works has taken certain actions in reliance on such authorization. However, this authorization shall be valid no longer than is reasonably necessary to accomplish the purpose of the actions for which it was given. This authorization will automatically expire 12 months from the end of involvement in treatment.

_____ _____ _____ _____

Signature Date Witness Date

Relationship to Client

☐ If client is a minor or incapable of signing, a copy of the appropriate legal documentation is attached if applicable. If I have joint custody, I have discussed this matter with the other legal guardian(s).

_____

☐ **DRIVERS LICENSE/IDENTIFICATION VERIFIED**