Authorization to Disclose Information

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve months from the date signed.

Client Name (printed): ______________________________ **Date of Birth**: ________________

____

Signature **Date**

PART 1: ***Primary Care Physician***

Name of Physician: ____

Practice/Group/Organization Name: ____

Mailing Address: ____

____

City State Zip Code

I grant permission for my therapist to release to my Primary Care Physician that I made my first appointment (please select one)**:**

____ **YES** ____ **NO**

PART 2: ***Referring Professional*** (such as a medical specialist, clergy, psychiatrist, etc.)

Name of Referring Professional: ____

Practice/Group/Organization Name: ____

Mailing Address: ____

____

City State Zip Code

I grant permission for my therapist to release to my Referring Professional that I made my first appointment (please select one)**:**

____ **YES** ____ **NO**

We are here to help.

17195 Cleveland Road, South Bend IN 46635 | **www.seasons-counseling.org** | P: (574) 277-0274 | F: (574) 271-7202