Avers & Biddle Counseling Associates LLC

1681 Crown Ave Suite 10, Lancaster, PA 17601
Phone: (717) 208-6686 Fax: (717) 208-6687

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____ Date of Birth: _____

I do hereby consent and authorize Avers & Biddle Counseling Associates LLC to receive from and/or disclose to:

Who I want to have my information:	Name: Address: Phone Number:

INFORMATION AUTHORIZED TO BE RELEASED:

❑ Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness or drug or alcohol abuse:
Date(s) of inpatient admission: _____

Date(s) of outpatient treatment: _____

❑ Psychological evaluation(s) or testing records, and

❑ Psychiatric evaluations, reports, or treatment notes and summaries.

❑ Treatment plans, recovery plans, aftercare plans.

❑ Admission and discharge summaries.

❑ Social histories, assessments with diagnoses, prognoses recommendations, and all similar documents.

❑ Billing records.

❑ Academic or educational records.

❑ A letter containing dates of treatment/summary of progress.

❑ Other: _____

THIS INFORMATION WILL BE USED FOR THE PURPOSE OF:

❑ Coordination of treatment

❑ Referral

❑ Discharge Planning

❑ Treatment Planning

❑ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

I authorize the release of my STD results, HIV testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone. ____ yes ____ no

I authorize the sharing of information regarding drug or alcohol treatment to the person(s) listed above.
___ yes ____no

NOTICE TO THE INDIVIDUAL GIVING THIS AUTHORIZATION

You may refuse to sign this form. You do not have to sign this form to receive treatment except:
-If the only purpose for providing you with services is to obtain information to disclose to someone else, then you must authorize that disclosure in order to receive services.
-If services are related to research, you may be required to authorize the use or disclosure of your health information for the research. This applies only to research related services and the use or disclosure of your health information for the research. Under Federal law, you do not have to allow us to receive the private notes from your counseling sessions with a mental health professional.
-If your information is given to others as allowed in the form, Federal privacy laws may not protect it. Also, if you have allowed information to go to an insurance company to obtain coverage, the insurance company may still have the legal right to use the information.

-Once information is disclosed on the basis of this authorization, Avers & Biddle Counseling Associates LLC, will have no control over the recipient's use of the information.

I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization. This authorization is effective immediately and will expire:

- ❏ Upon Discharge
- ❏ One year from this date
- ❏ Other: _____

_____	_____	_____
Client Signature (or parent/guardian for child under 14 years of age)	Date	Relationship to Client (Complete when client does not sign)

_____	_____
Witness Signature	Date