Karitas Counseling

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This Form cannot be used for the re-release of confidential information provided to Karitas Counseling by other individuals or agencies. Such requests should be referred to the original individual or agency.

I, _____, Date of Birth: _____, authorize Karitas Counseling to:

_____ Release to:
_____ Obtain from:
_____ Exchange with:

Name of Person/Organization: _____
If Organization, Attention: _____
Address: _____
Phone Number: _____
Fax Number: _____

The following information:

☐ Diagnosis	☐ Drug/Alcohol History	☐ Treatment Summary
☐ Attendance	☐ Mental Status Exam	☐ Progress Notes
☐ Prognosis	☐ Monthly Summary	☐ Discharge Summary
☐ Psychosocial Assessment	☐ Substance Abuse Assessment	☐ Psychiatric History

☐ Other: _____

For the dates of service beginning _____ and ending _____.

For the purpose of:

☐ Treatment Planning	☐ Coordination of Care	☐ Continuity of Treatment
☐ Family Involvement	☐ P.O/Attorney/Judge/Court/Caseworker	

This authorization is limited to only that information that I have requested above to be used or disclosed to the persons/facilities named herein. I hereby release Karitas Counseling and its employees from all legal responsibilities or liability that may arise from the use or disclosure of medical records and other health information in reliance on this authorization.

I understand that unless I revoke this authorization earlier, this authorization will automatically expire in one (1) year after the date of my signature as it appears below.
I understand I have the right to stop the use or release of information at any time, although I understand that I cannot do anything about information already used or disclosed under this authorization.

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. Any disclosure of medical record information by the recipients is not authorized except when implicit in the purposes of this disclosure. File copy is considered equivalent to the original.

_____ _____
Print Name of Client, Parent or Guardian Date Witness Signature Date

_____
Signature of Client, Parent or Guardian Date