MOTIVATE Counseling & Coaching

Joseph Murray LCSW PLLC

Consent for Release of Confidential Information

Consumer/Patient Name: _____ DOB: _____ /_____ /_____

Social Security Number: _____- _____ - _____ Dates of Treatment: _____

Information to be released from or exchanged with:

Name of Individual/ Agency: _____

Relationship to Consumer/ Patient: _____

Address: _____

_____

Purpose for Release: (Choose All that Apply)

☐ Continuity of Care

☐ Treatment Planning

☐ Coordination of Care

☐ Other: _____

Information to be Released and/or Exchanged: ☐ Psychiatric Evaluation ☐ Diagnostic Assessment ☐ Psychological History ☐ Psychological Evaluation ☐ Person-Centered Plan ☐ School Records ☐ Progress Notes ☐ Lab Reports ☐ Medication Records ☐ History and Physical Exams ☐ Continuing Care/ Discharge Plan ☐ Record of Appointment Attendance ☐ Other (Please specify): _____

☐ Specific Release of Any & All Information Related to the Identity, Diagnosis, Prognosis, or Treatment of Substance Abuse in accordance with Federal Law (42 C.F.R. § 2.31(a); 45 C.F.R. § 164.508(c)) for the purpose of: _____

☐ Specific Release of Any & All Information Related to HIV/AIDS & other communicable diseases to the extent that disclosure is permitted under 45 Code of Federal Regulations §§ 164.506 and 164.512(i) for the purpose of: _____

The following persons may sign the Consent for Release or Exchange of Confidential Information: (Please Choose Only One)
☐ Competent adult client ☐ Client's legally responsible person ☐ A minor client under the following conditions: pursuant to G.S. 90-21.5 when seeking services for venereal disease and other diseases reportable under G.S. 130A-135, pregnancy, abuse of controlled substances or alcohol, or emotional disturbances; when married or divorced; when emancipated by a decree issued by a court of competent jurisdiction; when a member of the armed forces ☐ Personal representative of a deceased client if the estate is being settles or next of kin of a deceased client if the estate is not being settled

_____ Initials I understand that information to be released may include information regarding drug abuse, alcohol abuse, and/ or psychological or psychiatric issues.

_____ Initials I certify this authorization is made voluntarily. I understand that the information to be released is protected under state and federal laws (including HIPAA) and cannot be re-disclosed without my further written consent unless provided for by the state and federal law.

_____ Initials I understand that this consent for release of confidential information shall be valid for a period not to exceed one year except under the following conditions: (1) a consent to continue established financial benefits shall be considered valid until cessation of benefits; or (2) a consent for release of information to the Division, Division of Motor Vehicles, the Courts and the Department of Correction for information needed in order to reinstate a client's driving privilege shall be considered valid until reinstatement of the client's driving privileges.

I understand that I may revoke this authorization at any time, except to the extent that the action has already been taken. I must make this request in writing to **MOTIVATE Counseling & Coaching**. If not previously revoked, this authorization will expire one year from the date of signature.

_____ ____/____/_____ _____ ____/____/_____

Signature of Client Date Signature of Parent/Guardian (if applicable) Date

_____ ____/____/_____

Signature of Witness Date