Release of Information Form

Client Name **DOB**

I, _____[Insert Name of Client], authorize Aspen Ridge Counseling, LLC to disclose to and/or obtain information between:

_____
[Insert Name of Other Person/Agency]

_____
[Address] [City] [State] [Zip]

_____
[Phone] [Fax] [E-mail]
the following information may be disclosed:

Description of Information to be Disclosed (✔ all that apply)

✔___ ***Presence/Participation in Treatment***	_____ Treatment Plan or Summary	_____ Continuing Care Plan
_____ Assessment	_____ Current Treatment Update	_____ Progress in Treatment
_____ Diagnosis	_____ Medication Management Info.	_____ Demographic Information
_____ Psychosocial Evaluation	_____Nursing/Medical Information	_____Psychotherapy Notes
_____ Psychological Evaluation	_____ Educational Information	_____Other_____
_____ Psychiatric Evaluation	_____ Discharge/Transfer Summary	_____Other_____
_____ Court Records		

Purpose
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. I may receive a copy of this authorization for my records.

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by contacting Aspen Ridge Counseling, LLC at *2880 West 4700 South Suite G-1, West Valley City, UT 84129*. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
Unless sooner revoked, this authorization expires one year after date signed by client.

Form of Disclosure
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to: verbally, in paper format or electronically.

Redisclosure
I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

⊠

_____
Signature of Client Date

_____
Signature of Parent/Guardian/Representative Relationship to Client Date

_____
Signature of Aspen Ridge Staff Witness Date