Release of Information Form

Client Full Name **Date of Birth** (MM/DD/YYYY)

I, ______________________________________[Insert Name of Client/Parent/Legal Guardian], authorize Aspen Ridge Counseling, LLC to disclose to and/or obtain information from:

[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 – Only data checked below will be released to the third party)

✔___ ***Presence/Participation in Treatment***	______ Billing & Payment Info.	______ Discharge/Transfer Summary
______ Assessment	______ Current Treatment Update	______ Continuing Care Plan
______ Diagnosis	______ Progress in Treatment	______ Demographic Information
______ Treatment Plan or Summary	______ Psychosocial Evaluation	______ Medication Management Info.
______ Psychotherapy Notes	______ Psychological Evaluation	______Other____________________
______ Progress Notes	______ Psychiatric Evaluation	______Other____________________

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 *2711 S 8500 W, Magna, UT, 84044*. 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 (Or Parent/Guardian/Representative if under 18) Relationship to Client Date

⌦

Signature of Aspen Ridge Staff Witness Date