

RECOARSE Counseling, PLLC
Adult Release of Information

I, _____ authorize RECOARSE Counseling, PLLC
(Client)

_____ to disclose to and/or obtain from: _____ the following
Debra J Farrell, PhD, LPC (Agency/Person to Disclose to)

information:

Description of Information to be Disclosed

- | | |
|--|---|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Diagnosis |
| <input type="checkbox"/> Treatment Plan or Summary | <input type="checkbox"/> Current Treatment Update |
| <input type="checkbox"/> Presence/Participation in Treatment | <input type="checkbox"/> Discharge/Transfer Summary |
| <input type="checkbox"/> Continuing Care Plan | <input type="checkbox"/> Progress in Treatment |
| <input type="checkbox"/> 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. If other purpose, please specify:

Revocation

I understand that I have a right to revoke this authorization at any time by sending written notification to RECOARSE Counseling, PLLC at 612 S. Creyts Rd., Suite B, Lansing, MI 48917.

Expiration

Unless sooner revoked, this consent expires on the following date: _____ or as otherwise indicated: _____.

Conditions

I further understand that RECOARSE Counseling, PLLC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequence: ***If services and communication is ordered by referring party/requestor are not in compliance with their expectation, their case may be closed or they may have other consequences deemed as non-compliance by that referring party.***

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.

Re-disclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed 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.

I will be given a copy of this authorization for my records.

Signature of Client

Date

Signature of Therapist

Date