RECOARSE Counseling, PLLC

Minor Release of Information

I,_____, of_____authorize RECOARSE Counseling, PLLC
(Parent/Guardian) (Minor Child)

_____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

_____ Assessment
_____ Treatment Plan or Summary
_____ Presence/Participation in Treatment
_____ Continuing Care Plan
_____Other_____
_____Diagnosis
_____Current Treatment Update
_____Discharge/Transfer Summary
_____Progress in Treatment

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.

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.

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

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Therapist Date