# Release of Information


## Trevor Walton, MMFT

### Masters in Marriage and Family Counseling

**COUNSELING FOR COUPLES, FAMILIES & INDIVIDUALS**

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Regarding:_____ Date of Birth_____
Client's Name (print or type)

Address:

I authorize _____ to
(Counselor/Therapist)

_____ Release information to: _____Receive information from: _____Exchange information with:

Name and Identifying Relationship to client: _____ Phone:_____

Address_____

My signature indicates that I understand my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations and/or under state specific provisions. I authorize the release/exchange of the following information (check all that applies):

__ Diagnosis, Progress, Prognosis & Recommendations
__ Alcohol/Substance Assessment/ Treatment/Recommendations
__ Psychotherapy Notes
__ (notes taken during session)
___Admission & Discharge summary
__ Social History
___ Joint session
__ Treatment summary
__ Attendance in Treatment
__ Psychiatric Evaluation (may include all of the above)
___ Medications Past/Current
___ Evaluations
___ Progress Notes
___ HIV/AIDS
___ Other:

The reason for releasing this information is:
__ Coordination of care __ At the request of the client __ Other: _____

**This authorization will expire 1 year from the date of signature below unless revoked prior to that date:**

- You may revoke this authorization at any time by notifying the above behavioral health provider at Hope Restored Nashville, in writing. However, revoking this authorization in writing will not affect any actions taken before receipt of that notice.
- The information disclosed based on your signed authorization may be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws.
- You do not need to sign this form to obtain services from Hope Restored Nashville.
- This authorization is completely voluntary, and you do not have to agree to authorize any disclosure.
- You have a right to a copy of this authorization once you have signed it.

Signature of Client_____ Date Signed_____

**Notice To Recipient of Information:**

This information has been disclosed to you from records which may be protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.