Counseling Center
Humphreys 131
Warrensburg, MO 64093
660-543-4060
FAX 660-543-8277

Authorization for Release and/or Receipt of Information

This form, when completed and signed by you, authorizes the Counseling Center or other parties to release protected information from your clinical record to whom you designate.

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Client Name (print) DOB

Authorizes the Counseling Center to:

☐ disclose ☐ obtain	☐ Assessment and treatment information including any substance use, substance related and addictive disorders, and any information about HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment. ☐ A copy of clinical records including any substance use, substance related and addictive disorders, and any information about HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment. ☐ Attendance Verification ☐ Other (provide description of the information that you want disclosed. Your description should be as specific and detailed as possible):	☐ to ☐ from ______________________ (Name) ______________________ (Agency) ______________________ (Address) ______________________ (City, State, Zip) ______________________ (Phone/Fax)

I am requesting this information be released for the following reasons: ("the request of the individual" is all that is required if you are/or were a Counseling Center client and you do not desire to state a specific purpose.)

☐ At the request of the individual
☐ ____

This authorization shall remain in effect:

☐ For one year from the date indicated below
☐ Until the following expiration date or event: ____________________________________

I understand I have the right to revoke this authorization, in writing, at any time by sending such written notification to the above designee(s). However, your revocation will not be effective to the extent that the above designee(s) have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

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Client Signature Date

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If the authorization is signed by a personal representative of the client, a description of such representative's authority to act for the client must be provided.

Revised 1/21/2020