Kolpia Counseling Services

607 Siskiyou Blvd. Ashland, OR. P: (541)482-1718 F: (541)482-0964

AUTHORIZATION FOR RELEASE OF RECORDS OR INFORMATION

The purpose of this form is to allow Kolpia Counseling Staff to communicate with your other care providers, doctors, counselors, legal counsel, social workers, case managers, representatives, referents, family and significant others. Please take a few moments to thoroughly fill out this form with the information you would like to share, with whom, and for how long. All highlighted areas need to be initialed if you are authorizing that item.

I, _____, _____, hereby give permission to Kolpia Counseling
(Print Name of Client) (Date of Birth)
and the staff performing services on behalf of Kolpia Counseling Services to share my information with the agencies or individuals listed below.

I authorize a release of information for the following organization, agency or individual.

Date: Telephone Number:

Address Fax Number:

This authorization allows Kolpia: ***To release information to ( ) To obtain info from ( ) To exchange information with ( )***
This release is active the period of time from_____ to _____.
I understand I have the right to revoke this release at any time _____ *(INITIAL PLEASE).*

Information to be Disclosed /Obtained:

CLIENT MUST INITIAL EACH ITEM OF INFORMATION TO BE RELEASED/OBTAINED:

_____Drug and Alcohol _____Mental Health _____Treatment Recommendations _____Attendance Records
_____Treatment Summary _____Family/Collateral Sessions _____ Urinalysis Results _____Medical Evaluation/History
_____ Prescriptions _____ Discharge Summary _____Other (specify)_____

Form of which information will be released or obtained: Verbally ( ) Written ( ) Fax ( )

The purpose of this authorization is: ( ) collaboration of care ( ) transfer of care ( ) verify attendance, or
( ) other (specify):_____

_____ _____
Signature of Client **Date**
Or Other Authorized Representative

NOTICE OF RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality protected by Federal and/or state law (42 CFR Part 2) . Federal Regulation (42 CFR Part 2) prohibits 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 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 information to criminally investigate or prosecute any alcohol or drug abuse patient.