A Center 4 Change
Counseling and Psychotherapy

Client Name: ___________________________ SS#:_______________ D.O.B.:__________________

We, [clients name]______________________ and/or [parent/guardian]________________________

authorize A Center 4 Change to:

(Please select) RELEASE TO OBTAIN FROM EXCHANGE INFORMATION WITH

Name : ____

Relationship to client: ____

Contact information: ____

Address: ____

for the following purpose(s):

____

Notes regarding contact:

____

____

I authorize the release of the following record(s): [Place initials beside the appropriate box(es)]

_______ Psychotic Diagnostic Interview

_______ Psychological Testing

_______ Treatment Summary

_______ Office/Medical Progress Notes

_______ Medication Information

_______ Other (please be specific)

____

*The following items must be initialed to be included in the use or disclosure of other health information:
_______*HIV/AIDS related health information and/or records
_______*Mental health information and/or records
_______*Information and/or records pertaining to sexually transmitted diseases.
_______*Drug/alcohol diagnosis, treatment, and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.)

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Client (Last Name, First Initial):
Client D.O.B.:

Authorization for Release of Information/Exchange of private health information
Non-psychotherapy notes

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice or verbal notice before two witnesses. Unless revoked earlier, this authorization will expire one (1) year from the date of signing or upon [insert other applicable expiration date if applicable]:

____

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. Unless otherwise provided by law, I may inspect or copy any information to be used or disclosed under this authorization.

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by such regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I further understand that they person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

Client Signature:____Date:_________

(*required if client is 16 years of age and receiving services according to KRS 214.185)

Parent/Guardian Signature:____Date:_________

(*required if client is under 18 years old and not receiving services for substance use disorder)

Relationship of Legal Representative to Individual:____

Signature of Witness:____Date:_________

**Psychotherapy notes require a separate authorization which cannot be combined with any other authorization.