intact
COUNSELING

9200 Montgomery Road Suite 15B (Building D)
Cincinnati, OH 45242 513.600.2554

I, _____ **(client name)**,

_____ **(date of birth),** give consent to this person or organization:

(Please include address, phone, fax.)

_____
_____
_____

to release or obtain information **to/from** the following person or organization:

(Please include address, phone, fax.)

_____
_____
_____

for the period of _____ **(beginning date)** to _____**(ending date)**

for the purposes of **(please specify)** _____.

Please release in accordance with the following specifications:

- ☐ Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness.
- ☐ Admission and discharge summaries
- ☐ Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents.
- ☐ Treatment, recovery, rehabilitation, aftercare plans and other similar plans.
- ☐ Social, family, educational, and vocational histories.
- ☐ Social work assessments, occupational therapy and vocational reports, and evaluations
- ☐ Progress, Case or similar notes.
- ☐ Evaluations and reports of consultants.
- ☐ Information about how the patient's condition(s) affects or has affected his or her ability to work, and to complete tasks or activities of daily living.
- ☐ Billing records.
- ☐ Academic and educational records, including achievement and other test results, reports of teachers' observations, and all other school or special education documents.
- ☐ HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated here –
  - ☐ Release all the above
  - ☐ Do not release these.
- ☐ Other information: _____

- I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of the organization listed above who is to supply this information. If I do this, it will prevent any disclosures after the date it is received but cannot change the fact that some information may have been sent or shared before that date.
- I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from the professional or facility listed above.
- I understand that I may inspect and have a copy of the health information described in this authorization. There may be a cost for this copy or other services.
- I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed and no longer protected by those regulations.
- I understand that the professional or facility listed above, may receive compensation for the use or disclosure of my health information. If that is the case, I understand and accept it.
- I affirm that anything in this form that was not clear to me has been explained adequately for my understanding. I have also received a copy of this completed form.

_____ _____

Signature of client or his/her legal guardian Date

_____ _____

Printed name of person above Relationship to above person

Description of personal representative's authority:

_____

I, a mental health professional, have discussed the issues above with the client and/or personal representative. My observations of his/her responses give me no reason to believe that this person is not fully competent to give informed and willing consent:

_____ _____

Signature of professional receiving authorization Date

_____

Printed name of professional receiving authorization