

KAIROS CHRISTIAN COUNSELING MINISTRIES, LLC.

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name _____

Date of Birth _____

If you receive information released with this form the following Federal Law applies directly to you:

This information has been disclosed to you from records 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 client.

I AUTHORIZE KAIROS CHRISTIAN COUNSELING MINISTRIES, LLC., TO RELEASE TO, OBTAIN FROM, or EXCHANGE WITH THE ORGANIZATION INDICATED BELOW CONCERNING TREATMENT OF THE ABOVE NAMED CLIENT. THIS AUTHORIZATION INCLUDES RELEASE OF INFORMATION CONCERNING HIV TESTING OR TREATMENT OF AIDS, AIDS-RELATED CONDITIONS, ALCOHOLISM, DRUG ADDICTION AND/OR PSYCHIATRIC/PSYCHOLOGICAL CONDITIONS.

THE PURPOSE OF THIS RELEASE IS TO:

____ Coordinate Treatment ____ Information for Ongoing Treatment

____ Other Purposes (specify): _____

TYPE OF INFORMATION TO BE DISCLOSED: ____ MH only ____ AOD Only ____ Both MH and AOD

____ Any information pertinent to the treatment of this client (Specify) _____

AMOUNT OF INFORMATION TO BE DISCLOSED:

____ Information covering the treatment of this client

____ Other amount of Information (Specify) _____

Name of Organization	
Address	
City/State/Zip	
Telephone Number	
Attention	

THE ABOVE INFORMATION IS RELEASED TO, OBTAINED FROM, EXCHANGED WITH THE ORGANIZATION ABOVE, (AGENCY, INSTITUTION, OR INDIVIDUAL), AND IS TO BE ACCOMPANIED BY A STATEMENT PROHIBITING REDISCLOSURE. THIS CONSENT MAY BE REVOKED IN WRITING AT ANY TIME. REVOCATION SHALL CAUSE RELEASE OF INFORMATION TO CEASE IMMEDIATELY EXCEPT THE EXTENT THE PROGRAM OR PERSON WHO IS TO MAKE THE DISCLOSURE HAS ALREADY ACTED IN RELIANCE ON IT. IF YOU ARE RECEIVING MENTAL HEALTH SERVICES YOUR CONSENT MUST BE REVOKED IN WRITING. THE AUTHORIZATION WILL REMAIN IN EFFECT 365 DAYS FROM THE DATE OF SIGNATURE (IF NO DATE SPECIFIED) OR UNTIL _____ (DATE CANNOT BE LONGER THAN 365 DAYS FROM DATE OF SIGNATURE). THIS RELEASE WILL EXPIRE UPON TERMINATION OF SERVICES. RECIPIENTS OF INFORMATION ARE PROHIBITED FROM REDISCLOSURE WITHOUT MY SPECIFIC AUTHORIZATION. A PHOTOCOPY OF THIS FORM IS CONSIDERED TO BE EQUIVALENT TO THE ORIGINAL.

CLIENT SIGNATURE _____

DATE _____

WITNESS _____

DATE _____

PARENT/LEGAL GUARDIAN SIGNATURE _____

DATE _____