Olive Branch Counseling Center
RELEASE OF INFORMATION

I, _____ Date of Birth _____
SS Number _____

Authorize:

Olive Branch Counseling Center
Joan E. Tucker, LPC/CR
c/o Judah Christian Community Church
972 Beechwood Rd; Whitehall, Ohio 43213
Phone:_____Fax_____
olivebranchcounseling@yahoo.com

To release to Or Receive From:	Agency/Person	_____
	Street	_____
	City, State, Zip	_____
	Phone/Fax	_____

The following Information: ___Psychosocial History ___Intake/Assessment ___Psychiatric Evaluation ___Summary of Treatment ___Discharge Summary ___Medications ___Other_____

Purpose for Obtaining Information: ___Continuity of Care ___Evaluation ___Third Party Payer/claims ___Pending legal action ___Housing ___Benefits ___Emergency Contacts ___Other (Be Specific) _____

This authorization is effective for medical records from _____(date) through _____(date).
This release automatically expires 90 days after the date on this release unless one of the following is checked and dated:

Expiration Date:

___ Expected long-term mental health/chemical dependency (up to 180 days) _____
___ Part of an approved research study (up to 180 days) _____
___ Less than 90 days: reason_____ _____

I authorize and acknowledge that this authorization extends to the above designated parts of the record which may include treatment for physical and mental illness and/or alcohol/drug abuse, and/or AIDS (Acquired Immunodeficiency Syndrome) and/or may include the results of HIV tests or the fact that an HIV test was performed. I understand my records are confidential and protected under State regulation and if they contain any reference to drug or alcohol abuse problems that they are further protected by 42 USC / 290ee-3, "Confidentiality of patient records" (for drugs), and 42USC / 290dd-3 "Confidentiality of patient records" (for alcohol).

I understands that this authorization extends to the release of information via U.S. mail, telephone, fax machine, or verbally. I understand that I may cancel this consent at any time (in writing) except to the extent that action has been taken in reliance on it.

Signed: _____ Date _____

Relationship if other than client: _____Parent/Guardian _____Authorized Representative

Witness:_____ Date _____

Records Copied: ___Intake/Assessment ___Summary of Treatment ___Psychiatric Evaluation ___Termination Summary ___Medication History ___ Other_____
Verbal discussion regarding:_____

Signature of person sending or talking _____ Date _____

FURTHER DISCLOSURE IS PROHIBITED

*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 information to criminally investigate or prosecute any alcohol or drug abuse client."

I hereby cancel my consent for the release of the above information.

Signed: _____ Date _____

Relationship if other than client: ___Parent/Guardian ___ Authorized Representative

Witness: _____ Date: _____