ANDREWS & ASSOCIATES
COUNSELING

Release of Information

Client's Name: _____DOB:_____SS#:_____

I authorize my therapist, _____,**to:** ☐ Disclose ☐ Receive Information from

Name/Co._____

Address: _____

City: _____State: _____ Zip:_____ Phone#: _____

Fax # _____ E-mail: _____

Exchange of Information Method:

☐ Mail to our office: Andrews & Associates Counseling, 1506 Browning Ave, Ste. 107, Manhattan, KS 66502

☐ Fax to our office: 785-776-7570 ☐ Contact/email therapist at_____

Purpose: ☐ Collaboration ☐ Continuity of Care ☐ Other _____

Information to Be Disclosed/Received/Exchanged:

☐ Exchange of all information listed below
☐ Complete health record
☐ Other _____
☐ Office/Progress Notes
☐ Treatment Plan Summary

Statement of Understanding:

I understand that if the person or entity that receives the described records/information is not a health care provider or health plan covered by federal privacy regulations, the records/information may be re-disclosed and no longer protected by those regulations. I also understand that certain records may be protected by federal or state law, including alcohol and drug treatment (Federal Law 42 CFR, Part 2; see page 2) or communicable diseases, and I am requesting that any and all such protected records be released under this authorization. I also understand that I may revoke this authorization at any time by delivering a written revocation to my therapist at Andrews & Associates Counseling (see page 2). If I revoke this authorization, it will have no effect on actions already taken in reliance on this form. I understand that my therapist at Andrews & Associates Counseling will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I authorize my therapist to obtain/disclose the records/information described. I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative. I also permit my therapist at Andrews & Associates to obtain/disclose the records/information upon presentation of a photocopy of this authorization

_____ _____
Signature of Client (12+ years must sign) Date

_____ _____
Signature of Parent (if applicable) Date

_____ _____
Signature of Witness Date

NOTICE

Confidentiality of Alcohol and Drug/Substance Abuse Patient Records

The confidentiality of alcohol and drug/substance abuse records maintained by Andrews & Associates Counseling is protected by Federal law and regulations. Generally, Andrews & Associates Counseling may not disclose to a person outside Andrews & Associates Counseling that a patient is receiving treatment related to alcohol and/or drug/substance abuse, or disclose any information identifying a patient as an alcohol or drug/substance abuser UNLESS:1.The patient consents in writing, 2.The disclosure is allowed by a court order, or 3.The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation. Violation of the Federal law and regulations of a treatment facility is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Federal law and regulations do not protect any information about a crime committed by a patient either at the treatment facility or against any person who works for the treatment facility or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities. (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR Part 2 for Federal regulations.) Prohibition on Re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulation prohibits you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

Andrews & Associates Counseling
1506 Browning Place, Suite 107 Manhattan, KS 66502
P.785-539-5455 F.785-776-7570
www.andrewsinc.net

RE-DISCLOSURE PROVISION: Note to receiving agencies/person: You may not re-disclose any of the information unless the person who consented to this disclosure specifically consents to such re-disclosure. Information released to said agency/person will be confidential and will not be released to another party without the signed consent of the client and/or his parent/guardian.