



Collaborative Counseling Services LLC

Request/Authorization to Release Confidential Records and Information

Client Information

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____

Clinic/Health Care Provider

Who has the information to be released?

Collaborative Counseling LLC
47 Marchwood Road, Suite 2A-8
Exton, PA 19341

Phone/Fax Number: (610) 340-2626

Receiving Party

Who will the information be released to?

Name _____ Relationship to Client _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Fax Number _____

47 Marchwood Road
Suite 2A-8
Exton, PA 19341
Phone/Fax: (610) 340-2626



Collaborative Counseling Services LLC

Information to Be Released

What will be released?

- Whether the client is in treatment or not
- Prognosis (diagnosis, opinion of how treatment will benefit client, general peculiarities of case)
- Brief statement regarding progress (client's denial, client's understanding of their condition and the disease concept, progress or lack of progress on goals, cooperation with treatment plan and rules)
- Brief statement regarding relapse and frequency of relapse (cannot identify specific drugs)

Purpose of Release

Why is information being released?

- Referral to other services
- Coordination of care
- Consultation with Doctor
- Consultation with other mental health provider
- Transfer of care
- Other _____

Signature of Client _____ Date _____

Signature of Provider _____ Date _____

This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____. This authorization may be canceled in writing at any time. A photocopy/fax of this authorization will be treated in the same way as an original. Your signature indicates that you have read and understand this form, and authorize release of your information as described above. I understand that I may refuse to sign this authorization and that refusal to sign will not affect treatment.

FOR THE RECIPIENT OF THE INFORMATION: If any of the requested records contain information regarding alcohol or drug abuse treatment, it may be protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or 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 use or 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 patient.

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