SamaraCare | Choose Stronger

FORM
2.4.5.1

AUTHORIZATION TO RELEASE AND/OR EXCHANGE INFORMATION

This form, after I complete and sign, authorizes my counselor to release and/or exchange protected information from your clinical record to the person or organization I designate.

I_____(DOB _____) authorize my counselor,_____,
to release and/or exchange the following information: ☐ verbally ☐ written ☐ copy of records ☐ other:_____

☐ Intake/Assessment ☐ Psychological Testing/Evaluation ☐ Psychosocial History
☐ Treatment Goals/Status ☐ Recommendations ☐ Medical Status/Medications
☐ Consultations ☐ Other:_____

This information should only be released to and/or exchanged with:
Name:_____ Phone/Fax:_____
Address:_____
City/State/ZIP:_____

_____I authorize the above named person to release and/or exchange protected information with my counselor.
(Initials)

I am requesting the release and/or exchange of this information for the following reason(s):

☐ Continuation or Coordination of Care ☐ Personal ☐ Other:_____
☐ Insurance ☐ Legal

This authorization shall remain in effect until _____(requires a specific date).

I have the right to revoke this authorization, in writing, at any time by sending such written notification to SamaraCare. However, my revocation will not be effective to the extent that I have taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my counselor generally may not condition counseling services upon my signing this authorization unless the counseling services are provided for the purpose of creating health information for a third party.

I understand I have the right to inspect the disclosed mental health information at any time.

I understand that Illinois law prohibits re-disclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes such re-disclosure.

_____ _____
Signature of Client Date

_____ _____ _____ _____
Parent/Guardian/Client Representative Date Signature of Witness Date

A copy of this form is available upon request.

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