Authorization for Release of Confidential Information

I understand that the information released may be subject to release by the person(s)/agency receiving it and no longer protected by the federal privacy regulations. I also understand that I may **revoke** this authorization/consent by notifying Courage Consulting & Counseling for the Individual or Family (CCCIF), in writing, of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions taken by CCCIF in reliance on it before I revoked it. I understand that I may **refuse** to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. A photocopy of this authorization will be treated in the same manner as the original.

Client Name: _____ DOB: _____

Address: _____

I authorize CCCIF, LLC to ____ receive information from and/or ____ release information to:

Agency/Individual: _____

Address: _____Zip_____

Phone: _____ FAX: _____

Information to be released/exchanged _____verbally and/or in _____writing (check the boxes that apply):

____ Name ___ Address ____ Phone Number ____ Date of Birth

OR

____ Diagnostic Report ____ Treatment Plan ____ Progress Report ____ Family / Social History

____ Testing Results ____ Medical History ____ Social Services Case Records ____ School Records

____ Psychological Evaluation ____ Psychiatric Evaluation ____ Discharge Summary Other_____

Courage Consulting & Counseling for the individual or family (CCCIF), LLC
3300 County Road 10, Suite 300A, Brooklyn Center, MN 55429
courageconsultingandcounseling.com | Phone: 651-440-5091 | Email:starla@courageconsultingandcounseling.com

ALL RECORDS PERTAINING TO MENTAL HEALTH, ALCOHOL AND/OR DRUG ABUSE, AND/OR AIDS/AIDS RELATED ILLNESSES WILL BE RELEASED UNLESS OTHERWISE INDICATED IN WRITING HERE:

This release is for the purpose of: Date Range:

_____ **To:**_____ **From:**_____

____ Coordination of services ____ Determination of eligibility for services ____ Social Service involvement

____ Continued / follow-up care ____ Court / Legal action ____ Other_____

I understand this authorization/consent will expire in **one year** or:_____
(Event or condition – not more than one year)

This form must be fully completed before signing.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent, Legal Guardian or Personal Representative, if applicable Date

_____ _____
Witness Date

Authorization/Consent to Release Info (01/11) Date of records requested: _____

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