Vancouver Counseling Group, LLC
1104 Main Street, Suite 300, Vancouver, WA 98660
(360) 718-8030 · (877) 861-5430 fax

Authorization to Release
Mental Health Treatment Information

I, ____, Date of Birth ________________________,

authorize Vancouver Counseling Group, LLC to disclose to and/or obtain from:

____ the following information:
[Name of Person or Title of Person or Organization]

Description of Information to be Disclosed:

(Patient/Client should initial each item to be disclosed)

_____ Assessment

_____ Diagnosis

_____ Psychosocial Evaluation

_____ Psychological Evaluation

_____ Psychiatric Evaluation

_____ Treatment Plan or Summary

_____ Current Treatment Update

_____ Medication Management Information

_____ Presence/Participation in Treatment

______Nursing/Medical Information

_____ Educational Information

_____ Discharge/Transfer Summary

_____ Continuing Care Plan

_____ Progress in Treatment

_____ Demographic Information

______Psychotherapy Notes*

(*Cannot be combined with any other disclosure)

______Other________________________

______Other________________________

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment, and when appropriate, coordinate treatment services. (This information will NOT be used for marketing purposes, sale of information, or research.)

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Vancouver Counseling Group, LLC at 1104 Main Street, Suite 300, Vancouver, WA 98660. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

This authorization expires one year from the effective date unless revoked earlier.

Conditions

I further understand that Vancouver Counseling Group, LLC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

____

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Form of Disclosure

Unless I have specifically requested in writing that the disclosure be made in a certain format, Vancouver Counseling Group, LLC reserves the right to disclose information as permitted by this authorization in any manner that she deems to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient (e.g., client, physician, agency) and the protected health information will no longer be protected by the HIPAA privacy regulations unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records if I wish to have a copy.

____ ____________________
Signature of Patient/Client Date

____ ____________________
Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient/client refuses to sign authorization

____ ____________________
Staff Member for Vancouver Counseling Group, LLC Date