



COUNSELING SERVICES OF GREATER BOSTON, LLC

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Name: _____ DOB: _____

I hereby authorize **Counseling Services of Greater Boston** to disclose to and obtain confidential health information from:

Name of Contact: _____

Organization (i.e. school/office): _____

Phone: _____ Email: _____

Description of information to be obtained and/or disclosed (please initial):

_____ Presence/Participation in Treatment

_____ Demographic Information

_____ Insurance and Financial Information

_____ Assessment

_____ Diagnosis

_____ Psychosocial Evaluation

_____ Psychological Evaluation

_____ Psychiatric Evaluation

_____ Treatment Plan or Summary

_____ Educational Information

_____ Medication Management Information

_____ Medical Information

_____ Substance Abuse Information

_____ Progress in Treatment or Progress Notes

_____ Psychotherapy Notes

_____ Discharge/Transfer Summary

_____ Other (please specify): _____

Purpose: This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations. If the purpose is other than as specified above, please specify: _____

I may revoke this authorization at any time, in writing, except to the extent that action has been taken in reliance upon it. If I do not revoke this authorization, it will expire one (1) one year after I have terminated treatment, unless otherwise indicated here: _____

Form of Disclosure: Unless specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information in any manner that we deem 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 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.

Signature of Client/Legal Representative

Full name and relationship to Client

Date