Olive Tree Counseling, Inc.
1981 E Palmer-Wasilla Hwy, Suite 220, Wasilla, AK 99654
Phone: (907) 357-6513 | Fax: (907) 357-6514

Authorization for the Disclosure of Information

I, (full name), _____, DOB: _____,
request and/or authorize Olive Tree Counseling, Inc., to the following **(please INITIAL):**
_____To DISCLOSE information -OR- _____To OBTAIN information to/from the following individual:

Full Name:_____ Phone:_____
Home Address:_____ Fax:_____

For the purpose of **(*INITIAL* all that apply):**

_____Further Treatment
_____Personal
_____Other (Please elaborate)_____
_____Coordination of Care
_____Legal Request

_____**MENTAL HEALTH AND/OR MEDICAL RECORDS, INCLUDING *(INITIALS)***

_____Intake and Discharge Summaries
_____Developmental History
_____Mental Health Evaluation
_____Medical History and Evaluations
_____Educational Records
_____Social History
_____Financial
_____Other

(Please elaborate)_____

_____**ALCOHOL AND DRUG TREATMENT RECORDS *(INITIALS)***

_____UA Results
_____Assessment/Interpretive Summary
_____Treatment Plan/Case Reviews
_____Message Client to Contact
_____Attendance
_____Discharge Summary
_____Financial
_____Other

(Please elaborate)_____
_____Progress Notes, Treatment Plan, and/or Closing Summary
_____HIV-Related Information

I have read, had explained to me, and fully understand this request/authorization to release and/or obtain records and/or information, including the nature of the records, their contents, and the consequences and/or implications of their release. This request is an entirely voluntary decision on the part myself as signed above. Further, I understand that my records are protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and cannot be disclosed unless permitted by the HIPAA regulations and/or other applicable State and Federal laws. Additionally, my records may be further protected by CFR Part 2, The Federal Regulations Governing the Confidentiality of Substance Abuse Records, and Olive Tree Counseling, Inc. will not disclose them without my written authorization. I understand that I may revoke this consent in writing at any time, except to the extent that action based on this consent has already been taken.

This consent **EXPIRES AUTOMATICALLY** ONE YEAR after the date on which it is signed, upon fulfillment of the purposes stated above, OR on the following date,_____, whichever comes last.

I understand that treatment, payment, or other benefits cannot be a condition upon my signing of this authorization and am entitled to a copy for my own records.

_____

Client Signature | Print Name, Client | Date

_____

Parent/Guardian/Representative Signature | Print Name, Parent/Guardian/Representative | Date

_____

Witness Signature | Print Name, Witness | Date