In-Home Counseling
counseling in the comfort of your own home

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Authorization for Release of Health Care Information

I, _____
Name of Client Date of Birth

_____
Address of Client Authorizing Release

_____
City, State, Zip of Client

_____
Person or Facility Name Address City State Zip

Phone #_____Fax # _____

Authorize Release of Information TO and FROM In-Home Counseling:
[ ] All Information (no limitations)
[ ] Medical History, Records, Labs, or Treatment
[ ] Psychiatric or Psychological Testing, Evaluation or Treatment
[ ] Substance Abuse Evaluation or Treatment
[ ] Discharge Planning
[ ] Attendance and Participation in Counseling Sessions

This information is to be used only for the purpose of evaluation and/or treatment, and to coordinate care.

My signature, giving consent, expires _____. The information released will be limited to the above identified requested information. The above requested information shall be released only to the requesting person or facility and the information may not be disclosed any further for any reason. I understand I have the right to inspect and copy the information released. It is further understood that I have been advised that I have the right to revoke this consent at any time. I understand that my refusal to consent to the release of information specified, will prevent disclosure of such information to the person named herein.

CLIENT: _____DATE: _____

WITNESS: _____DATE:_____

In sending this consent for Release of Information, I understand there is no charge for this information. If there is any charge for gathering this information and forwarding it to In-Home Counseling for Seniors, please cancel this request.