FULLER LIFE
Family Therapy Institute

Release of Information Consent

Client's Name: _____

Address: _____City: _____ State: _____ Zip: _____

Phone: _____ DOB: _____

I, _____, authorize _____to:

(❒ send ❒ receive) the following (❒ to ❒ from)

Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR PSYCHOTHERAPY NOTES.

❒ Academic testing results
❒ Progress reports
❒ Intelligence testing results
❒ Entire record, except progress notes
❒ Other: _____
❒ Psychological testing
❒ Summary reports
❒ Vocational testing results
❒ Personality profiles
❒ ALL OF THE ABOVE
❒ Service plans
❒ Psychological reports
❒ Medical reports
❒ Psychotherapy notes

The above information will be used for the following purposes:

❒ Planning appropriate treatment or program
❒ Continuing appropriate treatment or program
❒ Determining eligibility for benefits or program
❒ Case review ❒ Updating files ❒ Other: _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states very, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization

Your relationship to client: ❒ Self ❒ Parent/legal guardian ❒ Legal representative ❒ Other :_____

_____ Date _____/_____ _____ Date ___/____

CLIENT SIGNATURE PARENT/GUARDIAN/REPRESENTATIVE SIGNATURE

_____ Date ____/ _____/ ____ _____

THERAPIST SIGNATURE THERAPIST NAME

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