Owens Family Counseling
Authorization For Release Of Confidential Information

Chart#:_____

Client Name:_____ **DOB:**_____ **SS#**_____

Information is being released between **Owens Family Counseling** and

_____ _____ _____
Specify individual or organization | Address (city, state, zip code) | Telephone/Fax#

_____OFC is authorized to **release** information _____ OFC is authorized to **receive** information

Purpose of Disclosure: ___Continuing Care ___Court ___Family Involvement ___Insurance
___At the request of the Individual ___Other, please explain: _____

Choose From the Following:

___Psychological Assessment
___Verbal Communication
___Entire Chart
___Clinical Progress Notes
___Discharge Summary
___Lab
___Medical Assessment
___Letter
___Nursing Notes
___Treatment Plan
___Medical Progress Notes
___Other, specify_____

I understand that: I may revoke this authorization in writing any time prior to its expiration date by notifying the releasing agency in writing. However, if I revoke this authorization, it will not have any effect on any actions taken by the person/agency providing, disclosing, or receiving the information prior to receiving the revocation, nor shall it be valid to the extent that disclosing person/agency or receiving organization has taken action in reliance on this authorization.

I am not required to sign this form in order to receive services from OFC. The receiving person/agency is released from any liability and the undersigned will hold the receiving person/agency harmless for requesting or seeking my confidential health information.

The authorization will expire in six (6) months unless I provide an alternative date or event. This authorization will not apply to any dates of services that occur after the date this authorization is signed.

Expiration date: _____unless specified alternative date/condition of expiration:
_____

My signature also means that I have read this form and/or have had it read to me and explained to me in a language that I can understand. I authorize the release of the above requested health information.

_____ _____ _____ _____
Client signature | Date | Client's Authorize Representative /Relationship | Date

_____ _____
Witness | Date