Instructions:

Please print and complete the following forms prior to your first appointment. Your counselor will review the forms and answer any questions you may have when you meet.

If you have questions or concerns prior to your scheduled appointment please contact the Counseling and Outreach office at:

Phone: 812-330-6287
Email: counseling-r14@lists.ivytech.edu
Or visit us in room C111
GENERAL INFORMATION

Welcome to the Counseling and Outreach Program. We were established in 2007 as collaboration between Ivy Tech Community College and Indiana University’s Center for Human Growth. The Program is staffed by advanced graduate students in the Department of Counseling and Educational Psychology at Indiana University. Because the students are counselors in training, each counseling intern is carefully supervised by faculty members and/or other professionals in the community. All interns work without pay and are dedicated to your welfare; they will work with you to help you to explore and manage/resolve various issues and problems and reach your goals for personal growth. Some individuals come to the counseling with a definite problem(s) in mind while others wish to explore their own untapped potential or try out new behaviors or lifestyles. To get the most out of any counseling experience it is important to understand what you can expect from the agency and what we will expect from you. The following are principles and procedures by which the Counseling and Outreach Program operates:

Initial Contact with the Center
Every client is assigned to a counselor on the basis of the counselor's availability and clinical competencies. The assigned counselor will call or e-mail the client and set up the first counseling session. The personal information sheet will help the counselor understand what services you would like from the Program. By completing the form and initialing it you indicate your understanding and acceptance of the Program’s policies. If you do not understand any part of this material you may discuss it with the counselor before completing the information sheet. Confidentiality is strictly maintained at the Program.

Counseling at the Program
There are several important points you should keep in mind if you choose to receive counseling at the Program:

1. The counselors, supervisors and staff at our training site are a diverse group. We appreciate and celebrate differences of race, culture, ethnicity, gender, sexual orientation and age.

2. For purposes of supervision, counseling sessions may be monitored by videotape and audiotape. In this way, supervisors can discuss your situation with the counselor to maximize the benefits of your counseling experience.

Individual Counseling
If you decide to begin individual counseling, you not be charged a fee for sessions. We offer our services free of cost. Counseling sessions last fifty minutes, and it is important that they end on time because of other scheduled appointments.

Questions or Problems
If any questions or problems arise regarding the Program it is best to first discuss them with your counselor. In addition, you may seek help from the Director’s office at the Center for Human Growth (812-856-8348).
REQUEST AND AUTHORIZATION FOR SERVICES

I request and authorize the Ivy Tech Counseling and Outreach Program and its agents to provide and perform the services, treatments, examinations and procedures considered advisable by my provider.

I understand that I am consenting and agreeing only to those services my provider has advised and is qualified to provide within the scope of the provider's license, certification and training, or within the scope of those directly supervising the services received by me. It has also been explained to me that I will not be charged for counseling services.

I understand that information from my file, such as reports written by my counselor or forms that I have filled out, may be used in future research. I understand that the use of this information will never have my identifying information attached to it.

I further understand that my provider will not disclose information about my treatment to third parties without my written consent or except as provided by applicable law. Clients who are legally mandated to attend counseling please refer to confidentiality limits explained in the last paragraph of this form.

Please place your initials in the box by each of the following paragraphs in addition to signing this form to signify your agreement to these conditions of treatment.

☐ I have read this Request and Authorization for Services, the General Information Form about Center policies and procedures, and if relevant, the Group Information Form. I have had the opportunity to discuss any questions with my provider. I understand and agree to these policies, and I request that services be provided to me.

☐ Furthermore, I understand and give my consent to have all sessions videotaped, audio taped, and observed when needed for purposes of clinical supervision with the understand that all videotapes and audio tapes will be destroyed at the end of the semester. I understand that discussion of my case will be done so in a professional and ethical manner with the sole purpose of training students and providing the best possible care to the clients.

☐ I realize that in the event that I make any type of comment that would indicate to my counselor that I have, or that I intend to, endanger or inflict any type of physical harm to myself or any other individual, my counselor is required by law to take appropriate action, which may result in the breaching of confidentiality.

☐ If my treatment has been mandated by another social services agency, or any member of the justice system (e.g. a judge, probation officer or parole officer) I give my informed consent for my counselor to contact the specified social service referral agent regarding my attendance at counseling sessions. The release of any information other than attendance at counseling sessions will require a separate consent form, which is a signed release of confidential information that specifies the duration of the release and the nature of information to be disclosed.

__________________________________________________________  __________
Signature of Client or Legal Representative  Date

__________________________________________________________
Printed Name  CHG Supervisor
Ivy Tech Counseling and Outreach Program
Client Information Form

Today’s Date __________
Date of Birth: ______/_____/______

Name

Last
First
Middle initial

Gender: ☐ Male  ☐ Female

Address

___________________________________
Street

___________________________________
City, State, Zip

(    ) ______-__________
Home Phone number

May we leave a detailed message ☐ yes  ☐ no
Best time to call __________

(    ) ______-__________
Work Phone number

May we leave a detailed message ☐ yes  ☐ no
Best time to call __________

Email __________________________
May we email you to schedule an appointment ☐ yes  ☐ no

Best times for counseling appointments _________________________________________

What would you like to speak to a counselor about? ________________________________

Ethnicity (Check One)  Relationship Status (Check One)

☐ African-American  ☐ Single
☐ Asian American  ☐ Dating
☐ Caucasian  ☐ Married
☐ Latina/Latino ________________  ☐ Cohabiting
☐ Native American  ☐ Separated
☐ Pacific Islander  ☐ Divorced
☐ International student  ☐ Widowed

☐ If not included on this list please specify ________________________________

What country are you from? ________________________________
Do you have children living at home?  □ Yes  □ No
Number of children: __________  Ages of children ______________________
Are you an Ivy Tech student:  □ yes  □ no
Occupation __________________  □ Full-time  □ Part-time  □ Unemployed

Who referred you to the Counseling and Outreach office?
□ Self  □ Friend  □ other (please specify) ________________________________

Are you currently under the care of a physician?  □ yes  □ no
Date of last medical visit: ______/_____/_____
Name and location of physician:

Do you have any serious or chronic illnesses? (If yes, please specify)

Are you currently taking any medications? (If yes, please specify)

Have you sought counseling before at another agency or with another service provider?  □ yes  □ no
Name of agency or service provider and when you were last in counseling

Have you ever received counseling services at the Center for Human Growth or Ivy Tech Counseling and Outreach?
□ yes  □ no
If possible please specify when you were seen and your counselor’s name

Office use only

Intake Therapist: __________________________  Permanent Therapist: __________________________

Clinical Supervisor: __________________________
# Outcome Questionnaire (OQ®-45.2)

**Instructions:** Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth. Please do not make any marks in the shaded areas.

<table>
<thead>
<tr>
<th>Session #</th>
<th>Date / /</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes Frequent</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I get along well with others.</td>
<td>☐ 4</td>
<td>☐ 3</td>
<td>☐ 2</td>
<td>☐ 1</td>
</tr>
<tr>
<td>2. I feel lonely.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>3. I feel no interest in things.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>4. I feel stressed at work/school.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>5. I blame myself for things.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>6. I feel isolated.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>7. I feel unhappy in my marriage/significant relationship.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>8. I have thoughts of ending my life.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>9. I feel weak.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>10. I feel fearful.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark “never”)</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>12. I find my work/school satisfying.</td>
<td>☐ 4</td>
<td>☐ 3</td>
<td>☐ 2</td>
<td>☐ 1</td>
</tr>
<tr>
<td>13. I am a happy person.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>14. I work/study too much.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>15. I am concerned about family troubles.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>16. I have an unsatisfying sex life.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>17. I feel lonely.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>18. I have frequent arguments.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>19. I feel loved and wanted.</td>
<td>☐ 4</td>
<td>☐ 3</td>
<td>☐ 2</td>
<td>☐ 1</td>
</tr>
<tr>
<td>20. I enjoy my spare time.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>21. I feel hopeless about the future.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>22. I like myself.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>23. I have difficulty concentrating.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>24. I feel anxious.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>25. Nervous or worrying thoughts come into my mind that I cannot get rid of.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>26. I feel annoyed by people who criticize my drinking (or drug use).</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>27. I have an upset stomach.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>28. My heart pounds too much.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>29. I have trouble getting along with friends and close acquaintances.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>30. I am satisfied with my life.</td>
<td>☐ 4</td>
<td>☐ 3</td>
<td>☐ 2</td>
<td>☐ 1</td>
</tr>
<tr>
<td>31. I have trouble at work/school because of drinking or drug use.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>32. I feel that something bad is going to happen.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>33. I feel afraid of open spaces, driving, or being on buses, subways, and so forth.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>34. I feel nervous.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>35. I feel my love relationships are full and complete.</td>
<td>☐ 4</td>
<td>☐ 3</td>
<td>☐ 2</td>
<td>☐ 1</td>
</tr>
<tr>
<td>36. I feel that I am not doing well at work/school.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>37. I feel too many disagreements at work/school.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>38. I feel something is wrong with my mind.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>39. I have trouble falling asleep or staying asleep.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>40. I feel blue.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>41. I am satisfied with my relationships with others.</td>
<td>☐ 4</td>
<td>☐ 3</td>
<td>☐ 2</td>
<td>☐ 1</td>
</tr>
<tr>
<td>42. I feel angry enough at work/school to do something I might regret.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>43. I have headaches.</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
</tbody>
</table>

**Total**

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For More Information Contact: AMERICAN PROFESSIONAL CHEMICAL ALCOHOL SERVICES LLC E-MAIL: APCS@AOL.COM WEB: WWW.chemicalalcohols.com TOLL-FREE: 1-888-NEW-SCORE, (1-888-639-7627) FAX: (312) 785-5445

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. OUR PRACTICE PROVIDES THIS NOTICE TO COMPLY WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) OF 1996.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. The Notice takes effect 4-14-03, and will remain in effect until amended or replaced in accordance with applicable law at which time we are required to inform you of changes in privacy practices.

OUR PROMISE REGARDING YOUR PRIVACY

Our mission as a mental health provider is to protect your privacy and the confidentiality of your work in counseling. Please see our Authorization for Treatment and Informed Consent document for a complete explanation of the extent and limits of your confidentiality. Release of confidential information is dependent upon your written consent and a discussion with you about the content of the information to be released. Exceptions to this policy include emergencies where you are at risk of harming yourself or someone else (suicidal/homicidal risk). In this case your safety is our primary concern. Other exceptions include our legal obligation to report child abuse or neglect, elder abuse, or the abuse of a disabled person.

TYPES OF HEALTHCARE INFORMATION PROTECTED BY THE PRIVACY RULE

The following types of health care information are defined by the HIPAA privacy rules:

Health Information – any information, whether oral or recorded in any form, created or used by health care professionals.

Individually Identifiable Health Information (IIHI) – A subset of health information that either identifies the individual or that can be used to identify the individual.

Protected Health Information (PHI) – Individually Identifiable Health Information becomes Protected Health Information when it is transmitted or maintained in any form or medium. More specifically, PHI is information that relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or could reasonably be used to identify the individual.

Psychotherapy Notes – Notes recorded in any medium by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, join or family counseling session, and that are separated from the rest of the individual’s medical record. The definition of psychotherapy notes in the privacy rule specifically excludes information pertaining to medication prescription and monitoring, counseling session start and stop times, the modalities and
frequencies of treatment furnished, results of clinical tests and any summary of the following: functional status, treatment plan, symptoms, prognosis and progress to date.

The privacy rule applies to Protected Health Information (PHI). Information that does not identify an individual and provides no reasonable basis to believe the information can be used to identify a person is not considered PHI. When PHI is used or disclosed the privacy rule requires providers to share the minimum amount of information necessary to conduct the activity.

**USE AND DISCLOSURE OF YOUR HEALTH INFORMATION**

The following section describes how we may use and disclose health information. We will not use your health information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by your written request.

**Treatment:** We may use and or disclose your health information to a physician or other healthcare provider involved in your care.

**Payment:** We may use and or disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use or disclose your health information in connection with our office operations. Healthcare operations include quality of care assessment and improvement activities; reviewing the competence or qualification of healthcare professionals; evaluating practitioner and provider performance; conducting training programs; and accreditation, certification, licensing or credentialing activities. This also includes the use of personal information to contact you regarding appointments.

**Research:** We may disclose your health information for research purposes in limited circumstances where the research is subject to a review process and follows established protocols to ensure the privacy of health information. We are required to obtain written Authorization from you before using and disclosing your individually identifiable health information for research purposes.

**Marketing Communication:** We will not use your personal health information for marketing communication without your written consent.

**Emergency situations:** We may disclose your personal information to an organization assisting in a disaster relief effort or in an emergency situation to that your family can be notified about your condition, status, and location.

**Military and National Security:** Subject to certain requirements, we may disclose or use your health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

**Worker's Compensation:** We may disclose health information when authorized and necessary to comply with laws relating to worker’s compensation or other similar programs.

**Coroners, Medical Examiners, and Funeral Directors:** We may share personal health information with a coroner, medical examiner, or funeral director in the event of your death. If you are an organ donor we may release health information to organizations that oversee organ procurement or transplantation.

There are certain circumstances specified in the privacy act that may require us to disclose your health information to public health or legal authorities which do not require consent or authorization – these may include:
Public Health Issues

- Prevention and control of disease, injury or disability, including child abuse and neglect
- Reporting births and deaths
- Reporting reactions to medications or problems with products
- Notification of product recalls
- Notification of exposure to contaminants or communicable disease
- Notifications to the appropriate authorities in cases of suspected abuse, neglect or domestic violence when required by law

Law enforcement, Court orders, Judicial and Administrative Proceedings

We may release health information if asked to do so by a law enforcement or military official under the following circumstances:

- In response to a court order, subpoena, discovery request, warrant, summons or similar process.
- To identify or locate a suspect, fugitive, material witness, or missing person.
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person’s agreement.
- About an injury or death we believe may be the result of criminal conduct.
- In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.
- Concerning an inmate or person in lawful custody of a law enforcement agency or correctional facility.
- In order to defend ourselves, or any member of our Practice, in an actual or threatened action.

When allowed by law we will make every effort to notify you of such requests so that you may obtain an order protecting the information requested, if you so desire.

YOUR INDIVIDUAL RIGHTS

The following section describes your rights regarding the use and disclosure of your health information.

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. You must make your request in writing. We will provide information in the format you request if it is practical for us to do so. You may obtain a form to request access by using the contact information at the bottom of this notice. There may be charges for copying and postage, however we will provide a summary or explanation of your health information at no charge.

Disclosure Accounting: Beginning April 14, 2003, you have the right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, healthcare operations, and other specified exceptions. The time period include dates prior to the implementation of the HIPAA Privacy Regulations, April, 14, 2003. If you request this accounting more than once in a 12-month period we may charge you a reasonable, cost-based fee.

Restriction: You have the right to request in writing that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement except in the case of an emergency.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. This request must be made in writing.
Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or locations you request.

**Amendment:** You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We have the right to deny your request under certain circumstances including but not limited to: if we did not create the information you want changed, if it is not part of the health information kept by or for our Practice, and if the information is inaccurate or incomplete. If we deny your request we will provide you with a written explanation. If we accept your request to change information, we will make reasonable efforts to tell others (including people you name) about the change and to include the change in any future sharing of that information.

**Complaints:** You have the right to submit a complaint in writing if you feel your privacy rights have been violated. You will not be penalized in any way for making a complaint. Please notify our privacy officer in writing if you have a complaint. Contact information is listed below. It is also your right to file a complaint in writing with the U.S. Department of Health and Human Services.

**Notice:** You may request a paper copy of this notice at any time.

**QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or if you have questions or concerns, please contact our Center Coordinator between 8:00am and 5:00pm Monday through Friday and she will help you. Phone: 856-8302, Fax: 856-8317. Address: 201 N. Rose Ave., Bloomington, IN 47405.
This form is to verify your receipt of a copy of our privacy policy in compliance with the Health Insurance Portability and Accountability Act (HIPAA) designed to protect your private health information. Please sign and date below to indicate that you have received written information regarding this policy. Thank you.

Printed Name: ___________________________

Signature: _______________________________  Date: __________________
Client Name: ____________________________  Client Date of Birth: ___________________

I authorize the CHG-IT to:  ___ Release to  ___ receive from  ___ verbally communicate with

________________________________________________________________________

Name of person or agency providing treatment

________________________________________________________________________

Street address

________________________________________________________________________

City, state, and zip code

________________________________________________________________________

Phone  Fax

This information will be released/exchanged for the purpose of:

☐ Continuity of care  ☐ Treatment of client
☐ Assessment  ☐ Confirmation of referral
☐ Complete record  ☐ Other: __________________________

Please specify

I authorize facsimile transmission. Yes ___  No ___

________________________________________________________________________

I understand that information released may include information pertaining to alcohol and drug abuse on my part.

I understand that I may revoke this authorization in writing at any time and that no further disclosures shall be made after receipt of written revocation. I understand that all health information released prior to receipt of written revocation was properly released under this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by this authorization.

Waiver

I understand that my records are protected under state and federal confidentiality laws and that this consent would normally expire by law after a period of 60 days; however, I expressly waive my 60-day limitation and consent to disclosure and exchange of information as long as I am in treatment, or up to one year, unless specifically revoked by me in writing.

________________________________________________________________________

Client signature:  __________________________________  Date: _____________

*The authorization must be signed by the client unless the client is a minor or is physically or mentally incompetent. In those circumstances, the parent, guardian, or custodian of the client must provide the information below and sign this authorization.

Parent, Guardian, Custodian: ______________________  Signature: ___________________

Relationship to client: ______________________________  Date: _______________________

Address/Phone: ___________________________________________________________________