Centers for Behavioral Health ~ Release of Information Consent Form

I, ______________________________ for ______________________________,
Client Name: *if minor legal guardian's name* Client name
authorize my therapist and/or Centers for Behavioral Health to send and receive information to and from the following agencies or people:

INITIAL BELOW ~ *DO NOT CHECK*

* ____ Managed Care Plan* (your insurance provider) ______________________
____ Former Therapist ______________________
* ____ Physician* ______________________
____ If refusing consent to consult with your physician please state why: ______________________
____
* ____ EAP* (Required if using your Employee Assistance Provider) ______________________
____ Spouse ______________________
____ Hospital ______________________
____ Legal/Attorney ______________________
____ School or School Counselor ______________________
____ Other ______________________
____ Other ______________________
* ____ Records/Treatment Plans/Summary Reports *

(* These are required by Insurance or EAP providers for ongoing sessions, treatment, and/or payment.)

In according with the Health Insurance Portability and Accountability Act of 1996 (HIPPA): Information about your health which we receive from you or from others will mainly be used to provide you with treatment: planning, continuing, reviewing and/or updating appropriate treatment or program (s), determining eligibility for benefits, to arrange payment for our services, and for some other business activities which are called, in the law, health care operations. I understand that I may revoke this consent at any time by providing written notice: and after one year from date of file closing or last session attended, this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information.

In case of emergency whom may we contact? Name: ______________________

Phone Number: ______________________ Relationship: ______________________

* Signature of Client ______________________ Date: ____________
Signature of Parent/Guardian if Client is a minor

Signature of Therapist ______________________ Date: ____________