251 Essex Plaza, Essex, CT 06426 Tel: (860) 638-9169 Email: Clinician@changetalkllc.com

Consent for Release of Information

Client's Name: ______________________________________ Address: ____

City: __________________________ __ State: __________ Zip: __________ Phone: ________________________

DOB:____________ Email: ____

I, ___________________________________, (<<< print client/guardian name), authorize Change Talk LLC (CT) to both Release & Receive information

To & From the following person/organization:

Name:____ Address: ____

City: ______________________________ State: __________ Zip: ________ Phone: __________________________

Fax: ________________ ______ Email: ____

This release includes information from the client's Medical Record, but not the original or copy of the actual Medical Record. A separate authorization, as defined by HIPAA, is required for actual psychotherapy notes.

Initial each line for information that will be released. e.g., " _JP_ Progress in Treatment Report(s)"

______ Progress in Treatment Report(s)

______ Urine/Oral Drug Screen results

______ Treatment/Discharge Summary

______ **FULL DISCLOSURE**

______ Diagnostic Summary and Evaluation

______ Treatment Plan & Interventions

______ Use of Electronic Communication (email, text, etc.)

______ Other: ____

The above information will be used for the following purposes:

______ (Medical/Education) Obtaining/Releasing Information to/from Collateral Participants in Patient's Care; including, but not limited to, Prior/Current Treatment Providers, Educators, Family, Spouse, Providers of Continuing Care.

______ (Legal) Reporting to EAP's, DCF, Court, Attorney, Identified Court Representative, Judge, Probation/Parole Officer.

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 vary, 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 (describe) ________________________

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

CLIENT/GUARDIAN SIGNATURE: ____ Date ____/ _____/ ____

Witness: ____ Date ____/ _____/ ____