Progression Counseling Group (A Company of Hillary Schultz Therapy, LLC)
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Authorization to Exchange and/or Release Information from Third Party

Please complete this top portion to include the person or organization who you agree to release information to (do not put client information in the top portion):

Name of Person or Organization:_____

Address: _____

Telephone #:_____

Fax#: _____

Description of Information to be Disclosed:

Initial each item to be disclosed.

____Diagnostic Assessment/Intake ____Diagnosis

____Treatment Plan or Summary ____Progress in Treatment ____Presence/ Participation in Treatment

____Current Treatment Update ____Discharge/Transfer Summary ____Continuing Care Plan

____Other (please describe):

Purpose:

____Coordination of Services

____Demographic Information

____Educational Information

____Drug and Alcohol Addiction Records

____Psychological Evaluation

____Psychiatric Evaluation

____Medication Management Information

____HIV and AIDS status/treatment

____Court/Probation Requirements

___Treatment Coordination

____ Contact in Case of Emergency Risk

____Other (please describe):

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. Sharing information related to your psychotherapy history may pose certain, sometimes unknown, risks. Please be

sure you have discussed and evaluated these potential risks, with your primary therapist. In some cases, it may be best to authorize your therapist to write a letter with specific, requested information, instead of releasing psychotherapy records.

Expiration:

Unless sooner revoked, this consent expires 365 days from the date signed below unless as otherwise indicated: _____

Revocation:

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Progression Counseling Group. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Form of Disclosure:

Unless you have specifically requested in writing that the disclosure be made in a certain format, Progression Counseling Group reserves the right to disclose information as permitted by this authorization in any manner that is deem to be appropriate with applicable law, including, but not limited to, verbally, in paper format, or electronically. Requests of disclosures does not guarantee Progression Counseling Group will share requested information. Progression Counseling Group may consult with legal representation to determine which type or what disclosure is best. Therapists have the right to disclose information which we deem as minimally appropriate.

Redisclosure:

I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State confidentiality laws. Progression Counseling Group will not be responsible for the misuse or re-release of information by another individual, agency, or entity. Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2.

I may request a copy of this authorization for my records.

Signature of Client: _____

Date: _____

Signature of Parent/Guardian: _____

Date: _____

Signature of Witness: _____

Date: _____