

CLINICAL RECORD REQUEST / RELEASE AUTHORIZATION

Section 1

Client Name: _____ Client ID #: _____

Date of Birth: _____

Section 2

I authorize Healing Therapeutic Services, LLC to send information to:

I authorize Healing Therapeutic Services, LLC to receive information from:

Name of Agency _____

Address _____
Street, City, State, Zip Code

Phone _____ Fax _____

Contact Person _____

Section 3

Description of Information to be Disclosed

<input type="checkbox"/> Diagnostic Assessment/Evaluation	<input type="checkbox"/> Treatment Plan or Summary
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Billing Records
<input type="checkbox"/> ARMHS Functional Assessment & Treatment Plan	<input type="checkbox"/> Psychological/Psychiatric Assessment
<input type="checkbox"/> Chemical Dependency Evaluation Notes	<input type="checkbox"/> Other Facilities/Lab Reports
<input type="checkbox"/> All Mental Health Information-Dates of Service _____	
<input type="checkbox"/> Any and all medical records (including billing records and secondary records, mental health, chemical dependency/drug or alcohol abuse treatment records)	
<input type="checkbox"/> Other-specify _____	

Section 4

The Purpose of this Disclosure of information:

Ongoing Care Consultation Collateral Evaluation Family/Support Group Contact ARMHS

Outcomes Management Survey Other – Specify _____

Section 5

*I understand that I have a right to revoke this authorization at any time, in writing, but that the revocation will not have any effect on the information released prior to notification of cancellation. If I refuse to sign this consent, treatment will not be withheld. A photocopy of this authorization will be treated in the same manner as the original. I understand that this consent **expires ONE YEAR** from the date I sign it unless I request an earlier expiration in writing.*

I release Healing Therapeutic Services, LLC from any and all liability resulting from disclosure. I do not authorize re-release of this information to anyone. I have read this consent prior to signing and I understand its contents.

Signed _____ Date _____
Signature of Client or *Legal Guardian/Responsible Party if under 18

*Relationship to Client _____

Witness _____ Date _____

Healing Therapeutic Services, LLC Office Use Only

Faxed Mailed Picked Up Date: _____ Time of Day: _____ Initials: _____