JOURNEY COUNSELING SERVICES, PLLC

Authorization For Release of Information

I, _____, authorize Journey Counseling Services, PLLC, 1193 Hooksett Rd. #2, Hooksett, NH 03106, Telephone (603) 777-0361/Fax (603) 413-4633 to obtain from/disclose to/use my individually protected health information with:

_____.
(Name, address, telephone/fax numbers)

The purpose of this disclosure is: _____.

The information to be obtained/disclosed/used is as follows: (Check all that apply)

☐ Intake/Assessment
☐ Progress notes (including diagnosis and treatment)
☐ Results of testing/evaluations
☐ Course of treatment to include attendance/participation
☐ Discharge Summary
☐ Family and Medical History
☐ Legal History
☐ School records
☐ Other _____
☐ Alcohol and Drug Information (Protected pursuant to 42 CFR, part 42)

Any and all information relevant to a client's involvement with substances or involvement in the treatment of the same shall be protected by the Federal Laws of Confidentiality (42 CFS, Part 2) and shall not be disclosed without the written permission of said person. This release shall also expire in six months for alcohol and other drug information or at any time before then at the written request of the client. Re-disclosure of alcohol and other drug information received as a result of this release is prohibited.

The client or the parent/guardian must read and initial the following:

1. I understand that signing this release is voluntary. I am signing the form as a required condition for treatment. **Initials _____**
2. I understand that this authorization will expire on ____/____/____ (DD/MM/YR) **Initials _____**
3. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any effect on any actions that they took before they received the revocation. **Initials _____**
4. I am aware that the person/organization authorized to release this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. **Initials _____**
5. I have checked to make sure that all the blanks are filled in before signing the form. **Initials _____**
6. I understand that I may request and receive a copy of this form before and/or after I sign it. **Initials _____**

Signature of Client _____ Date of Birth: _____

Signature of Parent/Guardian (if applicable): _____

Signature of Witness: _____ Date: _____