CORNERSTONE
FAMILY SERVICES

Authorization for the Release of Information

(PLEASE PRINT)
CLIENT'S NAME: _____ D.O.B. ___/___/___
(First) (Middle) (Last)

Regarding the use or disclosure of protected health information about me, I hereby grant my permission for CORNERSTONE FAMILY SERVICES/_____ to:
Counselor Name/Credential

☐ Release information to and/or ☐ Receive information from:

Name of Agency and/or Individual: _____

Contact Information of Agency/Individual: _____

INFORMATION TO BE DISCLOSED:

☐ Clinical Diagnosis
☐ Drug/Alcohol Information
☐ Educational Information
☐ Individual Treatment Plan
☐ Initial Evaluation
☐ Psychiatric Evaluation
☐ Psychological Testing
☐ Other _____
☐ Psychosocial Summary
☐ Recommendations
☐ Treatment Summary

FOR THE PURPOSE OF:
☐ Consultation
☐ Psychological Evaluation
☐ Continuity of Treatment
☐ Other _____

I UNDERSTAND:

1. That the information used or disclosed may be subject to redisclosure by the agency or individual receiving it and no longer protected by federal privacy regulations. However, this information will not be re-released by CORNERSTONE FAMILY SERVICES without my written consent.
2. That I may withdraw or refuse this consent, in writing at any time. However, if I revoke this authorization it will not have any effect on actions taken by CORNERSTONE FAMILY SERVICES in reliance on it before revocation.
3. If drug and/or alcohol abuse information has been disclosed, I understand that my records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
4. I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

THIS AUTHORIZATION WILL EXPIRE:

☐ When received ☐ On ___/___/___ ☐ Other_____

Client/Parent/Guardian/Authorized Representative Signature _____ Date_____

Parent/Guardian/Authorized Representative Printed Name _____ (if applicable)

Representative's authority to act on behalf of client _____ (if applicable)

Witness signature _____ Date _____