Leslie Connolly, LCSW

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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Client Name:
_____DOB:_____

I, _____, hereby authorize ❑ Clinician ❑ Psychiatrist ❑

Other:_____

Client / Guardian

To RECEIVE the following information:	**To DISCLOSE the following information:**
(*Please check the appropriate box(es)*	*(Please check the appropriate box(es)*
❑ Any and all information relating to my care and treatment by the above-named provider.	❑ Any and all information relating to my care and treatment by the above-named provider.
❑ Only the following information: ❑ Demographics	❑ Only the following information: ❑ Demographics
❑ Assessment	❑ Assessment
❑ Program Notes	❑ Program Notes
❑ Treatment Plan	❑ Treatment Plan
❑ Discharge summary	❑ Discharge summary
❑ Other (please specify)	❑ Other (please specify)
_____ _____ __	_____ _____ __

Information to be RECEIVED FROM/DISCLOSED TO:

Name: _____ Company: _____

Address: _____

The purpose of this release is to:

❑ Coordination of services ❑ Obtain records ❑ Determine eligibility for services

❑ Legal purposes ❑ ISP/ITP planning

❑ Other (please specify):_____

If I have been diagnosed or treated for any of the following, I understand that Kristin Areglado Hurley, LCPC, CST needs my specific consent to disclose related information. In no event may any such information, if applicable, be disclosed without my specific consent. I authorize the above-named provider to make subsequent disclosure to the same recipient pursuant to this authorization. **Unless earlier revoked, this consent expires in 90 days or on the following date not to exceed one (1) year.**

Specified Date: **_____**

I authorize disclosure of information which refers to treatment of diagnosis of drug or alcohol abuse (Federal drug & alcohol regulations, 42 CFR 2.31). Such information may not be disclosed by the recipient without my specific written consent:

❑Yes ❑ No

I authorize release of any information that may relate to diagnosis/treatment for HIV, ARC, or AIDS:

❑Yes ❑ No

I authorize release of any information that may relate to mental health treatment:

❑Yes ❑ No

I understand that the above information may be covered by the rules of the Department of Health and Human Services (the “Rights of Recipients of Mental Health Services” or the “Rights of Recipients of Mental Health Services Who Are Children In Need of Treatment”).

I understand that I may refuse to release some of all of the information in the providers records, but that such refusal may result in improper diagnosis or treatment, denial of coverage or denial of a claim for health benefits or insurance, or other adverse consequences. The provider will not deny treatment on signing this authorization, unless the health care is solely for the purpose of creating the information listed above for the person listed above.

Leslie Connolly, LCSW, will NOT release information created by other practitioners or facilities. Statements added to records by clients and/or guardians will not be released without written consent. I understand that if the above listed information is disclosed, it is possible that it may be re-disclosed by the recipient, or that it may no longer be subject to confidentiality protections.

I waive my right to review this information prior to its disclosure: ❑Yes ❑ No

I authorize the provide to send/receive these records by fax: ❑Yes ❑ No Fax :_____

I acknowledge that I have been offered a copy of this authorization: ❑Yes ❑ No

I understand that I may cross out any words on this form with which I disagree, and that I may revoke this authorization at any time.

I understand the matters discussed on this form. I release Leslie Connolly, LCSW from any legal responsibility, or liability for the disclosure of the above information to the extent indicated and authorized herein.

Signatures:

Client_____

Authorized Representative

_____

Relationship to Client

_____

Witness

_____

*** *Request to To Revoke Statement below.* ***

*****Request to Revoke*****

I understand that I may revoke this authorization at any time by giving written or verbal notice to Kristin A. Hurley LCPC, CST, using this form or any other written statement. This will not affect information released prior to receiving my request to revoke. I understand that revoking this authorization may be the basis for denial of health benefits or other insurance coverage benefits.

My signature below officially revokes this authorization:

Client_____
__

Authorized Representative
_____

Relationship to Client
_____

Witness
_____