Bressler Counseling

Authorization for Release/Request of Information

Patient Name(s)_____ Date(s) of Birth_____

Authorization for (check all that apply) ___Request for Information ___Release of Information

I authorize Bressler Counseling to request/release information and /or records of the individual(s) named above.

I understand that my clinical record may include information relating to HIV/AIDS, behavioral or mental health services, and/or substance abuse services (42 CFR). This information may be released to/requested from the following:

1) **Facility/Person_____**
   Address_____
   Phone No._____
   The information and records are for the purpose of_____
   Information to be released includes:
   ____All information
   ____Specific information, such as_____

I understand that I have a right to cancel this authorization at any time by presenting my written cancellation to Bressler Counseling. I understand that the cancellation will not apply to information that has already been released in response to this authorization. I understand that the cancellation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If I do not cancel this authorization, it automatically expires as follows:

Please initial one choice:

____Six months after the date on which my treatment is completed
____On_____/_____/_____
____One time only for current records/information

I understand that authorizing the disclosure of this information is voluntary. I do not need to sign this form in order to receive treatment. I understand that the above information may be disclosed by the recipient of the information. Most health care providers and insurance plans must follow federal rules protecting the privacy of health information. However, Bressler Counseling cannot guarantee that others receiving the information will protect it.

_____ _____
Patient or Legal Representative Signature **Date**

_____
Relationship to Patient, If Signed by Legal Representative