

Release of Information Consent FOR THE TICC

Client's name: _____

I authorize **The Trauma-Informed
Counseling Center** to:

Send

Receive

The following information: _____

Medical History and Evaluation(s)

Mental Health Evaluations

Developmental and/or Social History

Educational Records

Progress Notes, and Treatment or Closing Summary

Contact Information & Court Details

To / From: _____

To: _____

From: _____

Contact: _____

Client: _____

Your relationship to client: _____

Self

Parent/Legal Guardian

Personal Representative

Other

The above information will be used
for the following purposes: _____

Planning Appropriate Treatment or Program

Continuing Appropriate Treatment or Program

Determining Eligibility for Benefits or Program

Case Review

Updating Files

Other:

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization. If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Signature: _____ Date: _____

Witness
Signature
(if client is
unable to
sign) _____ Date: _____