Behavioral Health Services *Alcohol and Substance Abuse Program*

PLEASE INITIAL ON EACH
LINE THAT APPLIES

Wilson Counseling
LIFE CAN BE GOOD

AUTHORIZATION FOR RELEASE OF INFORMATION

CLIENT NAME: _____ CLIENT DOB: _____

I hereby authorize release of the following information (Initial all that apply):

_____ Medical Evaluation _____ Laboratory Tests _____ Psychiatric/Psychological Evaluation
_____ Treatment Plans _____ Consultations _____ Educational Records
_____ Medical Records _____ Discharge Summary _____ Other: _____

_____ **FROM** _____ **TO (initial one or both) Wilson Counseling, LLC**
_____ **FROM** _____ **TO (initial one or both) the following:**

_____ DCBS Protection & Permanency
_____ Dept. for Juvenile Justice
_____ District/Family Court
_____ Attorney: _____
_____ Psychiatrist: _____
_____ DCBS Family Support
_____ LifeSkills
_____ Board of Education _____ (County)
_____ Guardian Ad Litem
_____ Other _____

Purpose of Release:

_____ Coordinate in treatment _____ At request of the undersigned _____ Other:_____

I understand and agree that this Authorization will be valid until 60 days after last date of service or revoked by client.

I understand that I can revoke or cancel this Authorization at any time by sending a letter to Wilson Counseling. If I do, it will prevent any releases after the date received but cannot undo that some information may have already been released. I understand that if the person/entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may no longer be protected by those regulations.

I understand that I do not have to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from Wilson Counseling, nor will it affect my eligibility for benefits.

I understand that I may inspect and have 1 free copy of the health information described herein.

____ I acknowledge that I was offered a copy of this completed Release of Information.

_____ _____
Signature and Printed Name of Client/Guardian/Representative Date

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