

Horgan & Saling Counseling Services LLC

141 Wall Street, Princeton, NJ 08540

609-580-1075

Authorization for Release of Information

I, _____, whose date of birth is _____, authorize Horgan & Saling Counseling Services LLC and my therapist _____ to disclose to and/or obtain from: _____ the following information:

Description of Information to be Disclosed

(Client should initial each item to be disclosed.)

- _____ Assessment
- _____ Diagnosis
- _____ Psychosocial Evaluation
- _____ Psychological Evaluation
- _____ Psychiatric Evaluation
- _____ Treatment Plan or Summary
- _____ Current Treatment Update
- _____ Medication Management Information
- _____ Presence/Participation in Treatment
- _____ Nursing/Medical Information
- _____ Toxicological Reports/Drug Screens
- _____ Educational Information
- _____ Discharge/Transfer Summary
- _____ Continuing Care Plan
- _____ Progress in Treatment
- _____ Demographic Information
- _____ Other _____
- _____ Other _____

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If other purpose, please specify:

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Horgan & Saling Counseling Services LLC at 141 Wall Street, Princeton, NJ 08540. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this consent expires on the following date: _____ or as otherwise indicated:

Conditions

I further understand that Horgan & Saling Counseling Services LLC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____

Forms of Disclosure

Horgan & Saling Counseling Services LLC

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Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Re-disclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances: _____

I will be given a copy of this authorization for my records.

Client Name

Signature

Date

Parent/Guardian/Personal Representative

Signature

Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.). _____

Check here if client refuses to sign authorization

Therapist Name

Signature

Date