Claudine Miller, LPC
7526 Big Bend Blvd, Webster Groves, MO 63119
Direct: 314-780-8328 • Fax: 314-475-3110

Client Name: _____ **DOB:** ___/___/___ **SSN:** _____

I hereby authorize Claudine Miller, LPC to RELEASE/OBTAIN information to:

Individual/Organization: _____

Address: _____

Phone: _____ **fax:** _____ **email:** _____

INFORMATION TO BE RELEASED/RECEIVED:

□Psychosocial History □Progress Notes □Diagnosis □Mental Health Assessment □Treatment Plan □Discharge Summary
□Assessment/Testing Results □Recommendations □Status in Program □Hospital/Medical Records □Dates of Service/Treatment
□School Records □Participation □Quarterly Reviews □Medications □Legal History, including arrest records & police reports
□Substance Abuse Screening Results, including urinalysis, breathalyzer, & lab results □Other(specify):_____

CONCERNING THE CARE OF CLIENT FROM:

_____ TO _____ **or** ALL PAST, PRESENT, & FUTURE TREATMENT PERIODS

RELEASE OF HIGHLY CONFIDENTIAL INFORMATION: By checking any of the boxes next to a category of Highly Confidential Information listed below, I specifically authorize the use and/or disclosure of the category of Highly Confidential Information indicated: □ Mental Illness □Substance Abuse □Abuse and Neglect □ Sexually Transmitted Diseases
□HIV/AIDS Testing or Treatment (regardless of results of testing) □Other :_____

PURPOSE FOR DISCLOSURE: (CHECK ALL APPLICABLE CATEGORIES)

□Personal □Transfer or Discharge Planning □Collaboration/Consultation □Insurance Eligibility/Benefits □Assessment
□Other: _____

I understand that I may inspect and obtain photocopies of the records disclosed. I understand that photocopies of this authorization will be considered as valid as the original. I understand that I may revoke this authorization at any time by informing Provident, Inc. in writing of my request for revocation or by signing below. I understand that this does not apply to information exchanged prior to the revocation date. I understand that information used or disclosed permitted by this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I understand that if I refuse to sign this authorization my records shall not be released. Failure to sign a release of information may result in refusal of treatment in certain instances. I waive and hold Provident, Inc. harmless from any liability resulting from the release of the above-authorized information.

This authorization expires on the following calendar date_____/_____/_____or one year from date of signature.

My signature below acknowledges that I have read, understand, and authorize the release of my protected health information.

Client Signature: _____ **Date:** ___/___/___

Parent/Guardian Signature: _____ **Date:** ___/___/___

Relationship to Client: _____

Witness Signature: _____ **Date:** ___/___/___

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of protected health information is not sufficient for this purpose. The federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse.

Notice of Revocation

I, _____, hereby revoke my authorization of this disclosure of information to the agency/ person listed above. This revocation effectively makes null and void any permission for disclosure of information given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

Revocation Signature: _____ **Date:** ___/___/___

Parent/Guardian Signature: _____ **Date:** ___/___/___

Relationship to Client: _____

Witness Signature: _____ **Date:** ___/___/___