Intake – Couples Counseling – Release of Information Form

FRIEDMAN
Counseling Services, LLC

My First and Last Name _____ Date of Birth (XX/XX/XXXX) _____

Regarding the use or disclosure of protected health information about me, I hereby grant permission for Friedman Counseling Services, LLC, and my clinician to:
(Check box below if granting permission)

☐ both release information to and receive information from

First and Last Name of Spouse/Partner/Co-parent/Other _____.

Phone # (Spouse/Partner/Co-parent/Other) _____

Email Address (Spouse/Partner/Co-parent/Other) _____

My Relationship to the Above-Named Spouse/Partner/Co-parent/Other is that of:

☐ Romantic Partner ☐ Co-Parent ☐ Other _____
☐ Spouse ☐ Family Member

Information to be disclosed may include the following: Clinical Diagnosis, Drug/Alcohol Treatment, Educational Information, Individual Treatment Plan, Initial Evaluation, Psychiatric Evaluation, Psychological Testing, Psychosocial Summary, Recommendations, and Treatment Summary.

Information to be disclosed will be used for the purpose of:

☐ Pre-Marital/Couples/Family/Co-Parent Counseling

☐ Other _____

I understand:

A. That the information used or disclosed may be subject to redisclosure by the agency or individual receiving it and no longer protected by federal privacy regulations. However, this information will not be re-released by Friedman Counseling Services, LLC, without my written consent.
B. That I may withdraw or refuse this consent in writing at any time. However, if I revoke this authorization it will not have any effect on actions taken by Friedman Counseling Services, LLC, in reliance on it before revocation.
C. That if drug and/or alcohol abuse information has been disclosed, my records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
D. That I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

This Authorization for the Release of Information will expire 365 days from the date of authorization (i.e., the Date of Signature).

My Signature _____ Today's Date (XX/XX/XXXX) _____