Rochester Area Counseling Services

Authorization to Release, Exchange or Obtain Information

I, _____Date of Birth: _____
Client's name (and authorized person, if client a minor)

Authorize Rochester Area Counseling Services to release information to the following person or organization and for the following person or organization to release information to Rochester Area Counseling Services:

_____
(Person/Organization) (Telephone Number)

_____
(Address) (Fax)

I understand that the purpose of the disclosure is to:

☐ Comply with client's request ☐ Other _____

☐ Coordinate treatment via phone ☐ Coordinate treatment by sending letter

☐ Coordinate treatment via phone and by sending letter

The information to be disclosed includes:

☐ All mental health information ☐ Alcohol and drug abuse information

☐ Other _____

I understand that I may revoke, in writing, this authorization at any time, except to the extent that action has already been taken in reliance on it. I understand that this information may be re-disclosed by the recipient and at that time would no longer be protected by the originator. I understand that Rochester Area Counseling Services may not condition services upon my signing this authorization unless the services are provided to me for the purpose of creating health information for a third party. This authorization for release of information will expire on: _____ (when left blank, will expire one year from the date signed).

_____ _____ _____
Client Name (Printed) Client Signature Date Signed

_____ _____ _____
Witness Name (Printed) Witness Signature Date Signed