Center for Tranquil Transitions, LLC

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Client Authorization Form

Client Name: _____ DOB: _____ SSN: _____

I _____, authorize _____ to RELEASE/RECEIVE information TO/FROM:

Name/Agency: _____
Address: _____
_____
Telephone: _____ Fax: _____

The specific information to be released in VERBAL/WRITTEN format is:

☐ Progress Notes ☐ Test Results ☐ Psychosocial History

☐ Treatment Plan ☐ Diagnosis ☐ Other: _____

For the specific purpose of:

☐ Facilitating Treatment ☐ Continuation of Care ☐ Evaluation

☐ Other_____

I understand that I have the right to refuse its authorization. I also agree to release _____, from any liability arising from the release of this information to the designated persons or agencies. I understand that my counselor may be compelled to release information without my permission under certain legally required circumstances.

This release is limited to information which is necessary for effective case management and treatment. I understand the material released may include information about drug and alcohol use.

I understand that my records are protected under the 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.

This consent may be revoked at any time except to the extent that the persons/agency, which is to make disclosure, has already taken action in reliance upon it. This authorization will expire one (1) year from the date signed. Also I understand that a photocopy of this authorization is valid for release of the above information.

Signature of Client: _____ Date: _____

Signature of legal Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____