Four Feathers Counseling
hope for generations

Authorization to Request/Release Confidential Information

Client(s) Name: _____ DOB:_____

Family member(s) Name: _____

Below are the names and phone numbers of agencies, organizations, or individuals with whom information may be exchanged as indicated by **initials;**

	Phone	YES	NO
Four Feathers team members, supervisor			
Teller County District Court and Woodland Park Municipal Court			
El Paso Country District Court and Colorado Springs Municipal Court			
Ft. Carson, Evans Army Medical/Behavioral Health Case manager			
DYC/DHS/DSS Caseworker:_____ and/or Current CW and Supervisor PCP: _____ and Supervisor			
School District: #_____Personnel:_____			
Attorney: _____			

Four Feathers Counseling
hope for generations

GAL: _____ and/or Current GAL			
Psychiatrist:_____			
Other: _____			
Other: _____			

Information that may be requested or released (Please *initial one*):

Please be aware that this release of information may include mental health condition and treatment information and/or alcohol or substance abuse information. A copy of this release of information may be used with the same effectiveness of the original.

(_____) Any information you disclose while receiving services from Four Feathers may be released. Any **exceptions are noted** as follows. Please write "no exceptions" if there are no exceptions placed on this release.

_____
_____
_____

OR
(_____) Only specific information may be requested/released. Please indicate what specific information can be requested/released.

_____
_____
_____

Four Feathers Counseling
hope for generations

This authorization shall be valid for **initial** **(Please one):**

(_____) 1 year from the date of signature
(_____) 1.5 years after discharge from services
(_____) Specify date or event: _____

You may revoke this release, in writing, except to the extent that Four Feathers Counseling has taken action in reliance thereon. The information disclosed may be subject to redisclosure by the recipient and thus no longer protected by the HIPAA privacy regulation.

_____ _____

Client Signature parent/guardian authorized to release information (if client less than 15 years) | Relationship to Client | Date

_____ _____

Client Signature parent/guardian authorized to release information (if client less than 15 years) | Relationship to Client | Date

Notice to Recipients of this Release/Authorization: prohibition on re-disclosure

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 medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.