Four Feathers Counseling
HOPE FOR GENERATIONS

Authorization to Request/Release

Confidential Information/Important Contacts

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;**

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	Phone: _____
		DYC/DHS/DSS Caseworker: _____and/or Current CW and Supervisor	Phone: _____
		PCP:_____ and Supervisor	Phone: _____
		School District: #_____Personnel	Phone: _____
		Attorney: _____	Phone: _____
		GAL: _____ and/or Current GAL	Phone: _____
		Psychiatrist: _____	Phone: _____
		Other: _____	Phone: _____
		Other: _____	Phone: _____

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.

_____

_____

_____

_____

This authorization shall be valid for (Please initial 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 12 years) | Relationship to Client | Date

_____ _____ _____

Signature of parent/guardian authorized to release information (if client less than 12 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.