Integrative Psychology & Counseling Specialists
Release of Information Consent to All Others

This form is optional. The purpose of this form is to allow communication between Integrative Psychology & Counseling Specialists and anyone else you wish to designate as a contact person (doctors, family members, etc). You will need to complete one for each person you would like IPCS to communicate with.

Client's Name: _____
Address: _____ City: _____ State: ____ Zip: _____
Phone: _____ DOB: _____

I, _____ ,
authorize
Integrative Psychology & Counseling Specialists to: ____ (send) ____ (receive) the following healthcare
information:_____
(to) ____ (from) ____
Name:
_____
_____
Address: _____ City: _____ State: ____ Zip: _____
Phone:_____ Fax:_____

***A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR PSYCHOTHERAPY NOTES.**

___ Academic testing results
___ Behavior programs
___ Progress reports
___ Intelligence testing results
___ Medical reports
___ Personality profiles
___ Psychological reports
___ Psychological testing results
___ Service plans
___ Summary reports
___ Vocational testing results
___ Entire record, except psychotherapy notes
____ Other, specify_____

The above information will be used for the following purposes:

____Planning appropriate treatment or program
_____Continuing appropriate treatment or program
____Determining eligibility for benefits or program
_____Case review
_____ Updating files
_____ Other (specify)

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a

health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and this consent automatically expires after _____ _____ (one year if left blank). I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to client: ____Self_____ Parent/legal guardian _____Personal representative __Other (describe)_____

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: _____ Date: ___/___/_____

Parent/guardian/personal representative (if applicable)

Signature: _____ Date: ___/___/_____
Witness (if client is unable to sign): _____ Date: ___/___/_____