Radiant Counseling, LLC

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Release of Information

Client Name: ______________________ Birth Date: ______________ Soc.Sec #: ______________

I understand by signing this form, I am allowing Radiant Counseling to disclose to and/or obtain information concerning the above named client to / from:
Person or Agency: ____
Address: ____
Phone: ________________________ Fax: __________________________

Description of Information to be disclosed:

□ Assessment □ Testing Information □ Diagnosis
□ Evaluation □ Treatment Plan □ Educational Information
□ Continuing Care Plan □ Progress Notes □ Medication List
□ Billing Information □ Presence/Participation in Treatment
□ Other ____

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify: ____

This authorization is voluntary and I may cancel this consent to release information at any time by sending written notice to Radiant Counseling at the address above. I understand that any release which was made prior to my cancellation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized re-disclosures and once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting Radiant Counseling at the above address.

I further understand that Radiant Counseling may not require this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in denial of those services.

I understand that this authorization will remain in effect for the period necessary to complete the sharing of information related to services provided to me, not to exceed 365 days from the date below. After 365 days, this authorization expires, unless it is revoked by me previously.

I understand that unless otherwise limited by state or federal regulations, and unless action has been taken based on my consent, I may withdraw this consent at any time.

____ ____________________
Signature of Client, Parent, Guardian/ Relationship to the Client Date

____ ____________________
Signature of Witness Date