Quest Counseling LLC

Initiative.Imagination.Individuality

Release of Information for Previous Behavioral Health Professionals

I, ____ whose Date of Birth is ______,

authorize Quest Counseling LLC to disclose to and/or obtain from:

Name/Organization_____________________________________Phone #______________

Initial Description of Information to be Disclosed

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
______Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
______Discharge/Transfer Summary
______Other___________________

Purpose: To share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time.

Expiration: Unless sooner revoked, this authorization expires on the following date: _________________

Conditions: I further understand that Quest Counseling LLC will not condition my treatment on whether I give authorization for the requested disclosure

____
Signature of Patient/Client Date

____
Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient/client refuses to sign authorization

____
Signature of Staff Witness Date