COUNSELING *Solutions* **OF ALASKA, LLC**

701 East Tudor Road, Suite 215, Anchorage, Alaska 99503
phone: 907-644-8044, records fax: 907-770-0357

Authorization for Release of Information

Name: _____ Date of Birth: _____ SSN (last 4): _____

I, the [ ] client / [ ] parent / [ ] legal guardian, hereby authorize Counseling Solutions of Alaska, LLC, to:

[ ] Release Counseling Solutions' information to: [ ] Obtain information from:

Person / Organization: _____

Phone / Fax: _____

Address: _____

Please send records by: [ ] fax [ ] mail or [ ] I will pick them up in person.

Your contact information (phone # with voice-mail, or e-mail): _____.

Fees: $25.00 for records of 25 – 100 pages or $50.00 for over 100 pages; fee is waived when records sent directly to another provider.

Purpose of This Request: [ ] Treatment [ ] Personal [ ] Legal [ ] Other: _____

For Treatment Dates: _____

Information to be Released: ___ Verbal Exchange of Information
initials

Medication Management	Counseling	Other
___ Psychiatric Assessment *initials*	___ Therapist Intake Assessment *initials*	___ Gastric Bypass Mental Health Evaluation *initials*
___ Pharmacologic Progress Notes *initials*	___ Therapy Progress Notes *initials*	___ Psychological Testing *initials*
___ Medication Tracking Sheet *initials*	.	___ _____ *initials*
___ Laboratory Reports *initials*		___ _____ *initials*

I authorize the release of records relating to:

_____ Mental Health (**required**) *initials* _____ Alcohol/Substance Abuse *(if applicable)* *initials* _____ HIV/AIDS status *(if applicable)* *initials*

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to ensure treatment, payment, enrollment or eligibility of benefits. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164,524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I understand that I have the right to revoke this authorization at any time, except to the extent that action has already been taken in reliance on this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Counseling Solutions of Alaska, LLC. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. Without a written revocation, this authorization will remain in effect for one (1) year, unless an earlier date or condition / event is specified here:

_____

_____ _____ _____

Signature of Client or Parent / Guardian / Legal Representative | Relationship *(if applicable)* | Date

_____ _____

Signature of Witness (**required**) | Date

A photocopy or faxed copy shall be considered as valid as the original.