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Release of Confidential Information

Instructions: This documentation is optional. By signing this form, you understand that Lisa Cree Counseling, LLC will not condition your treatment on whether authorization is given for the requested disclosure. This form must be signed if you would like the provider to communicate or share information with others. There are limits to confidentiality, as described on the website and in the office policy handouts you were given upon admission. You also understand that information as permitted by this authorization may be shared in any manner that is deemed to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

I, _____, authorize Lisa Cree, LMHC, LCAC to receive from and/or

disclose to: _____
Name of Person/Organization

Person/Organization's address:

_____
Street Address City State Zip

Phone number of person/organization: _____ Fax: _____

I understand this document will expire: When revoked [ ] On this specific date: _____

The following information may be released/shared: (Client to initial areas of approval)

Assessment/Testing Results [ ]
Admission to Treatment [ ]
Attendance [ ]
Discharge Summary [ ]
Progress Notes dated _____ to _____
Billing and Claim Information [ ]
Treatment Progress Report [ ]
Any and All information [ ]
Drug and Alcohol Information [ ]
Other (specify) _____

The purpose of disclosure authorized is for (client to initial areas of approval):

Court Involvement [ ]
Participation in Treatment [ ]
Continuity of Care [ ]
Other (specify) _____

By signing below, I acknowledge that the above information about me may be released, discussed, or disclosed. I understand that my records are protected under Federal Regulations governing Confidentiality of Protected Health Information (PHI) under HIPAA and Confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2. I also understand that I may revoke this authorization at any time and must do so in writing and present this written revocation to Lisa Cree, LMHC, LCAC. I understand that once information is disclosed as per my authorization, the recipient, in accordance with applicable laws and regulations, may re-disclose the information and it might not be protected by federal or state privacy regulations.

I have been offered a copy of this authorization.

_____ _____
Client Signature/Parent or Guardian if Under 18 Date

_____ _____
Witness Signature Date

Revised 12/3/2023