Access Counseling Services, LLC

(rev. 04/22)

AUTHORIZATION FOR RELEASE OF INFORMATION

CLIENT NAME:		DATE OF BIRTH	

I hereby authorize:

Access Counseling Services	To Exchange Information With:	Name of Individual/Institution	
4434 S. Dixie Hwy		Address	
Middletown, Ohio 45044		City/Stat/Zip Code	
Phone: (513)649-8008		Phone	
Fax: (513)649-8004		Fax	

I authorize the following information to be released:

X	Diagnostic Assessment	X	Urine Screen/Lab Results
X	Discharge Summary	X	Progress Notes
X	Treatment Plan	X	Other (Specify) any and all records pertaining to treatment
X	Consultation	X	Other (Specify)

This authorization for release/disclosure is for the following purpose(s):

coordination of care, progress report

Specify the amount of information to be disclosed: (mark appropriate boxes)

	Information from the past three months	X	Information from the most recent admission		
	Information from the past year		Other: specify:	From:	To

This authorization includes release of records relating to: (mark appropriate boxes)

X	Diagnoses and/or treatment of substance use disorders		HIV test results
	AIDS/AIDS Related Complex (ARC) diagnoses and/or treatment		Diagnoses and/or treatment relating to other communicable diseases

Indicate here any additional exceptions or exclusions to information released:

N/A

This authorization will remain in effect for 1 year unless revoked or an earlier date or condition/event is specified here:

N/A

My refusal to sign this authorization will NOT affect my treatment, payment, enrollment in a health plan, or eligibility for benefits.

NOTE: 42 CFR Part 2 prohibits unauthorized disclosure of these records.

Signature of Client/Guardian/Personal Representative*	Date Signed	Print Name
Signature of Witness	Date Signed	Print Name

*If signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

Ex. Parent, legal guardian, POA, Executor/Administrator, etc.

To Revoke:

I understand that I have the right to revoke this authorization at any time by submitting a written request to revoke authorization, and that the revocation will be effective except to the extent that Access Counseling Services, LLC has already acted in reliance on my authorization.

I hereby revoke this authorization effective as of:

Signature of Client/Guardian/Personal Representative:	Date Signed:	Print Name