

Ruth Weinberg LPC
1726 Clarkson Street, Denver, Colorado 80218
ruth@ruthweinberg.com
720.432.1163

RELEASE/EXCHANGE OF INFORMATION

I, _____ hereby authorize and request
(Please Print Name)

the exchange of information between Ruth Weinberg, MS, LPC and

(Name of Person)

(Name of Agency)

(Phone Number)

The information exchange may include all confidential medical, psychological or other appropriate information acquired in the course of evaluation and treatment.

The purpose of the information exchange is to assist in providing thorough and effective counseling services and will not be used for any other reason.

I understand that this consent will be in effect for one year following the date on this form. I understand that I may revoke this consent at any time by informing Ruth Weinberg MS, LPC in writing. In consideration of this consent, I hereby release the above parties from legal liability for the exchange of information.

Signature: _____ Date: _____

I, _____, whose Date of Birth is _____,
Name of Client

authorize Ruth Weinberg, MS, LPC to disclose to and/or obtain from:

Name of Person or Title of Person or Organization

the following information:

Description of Information to be Disclosed
(Patient/Client should initial each item to be disclosed)

- _____ Assessment
- _____ Diagnosis
- _____ Psychosocial Evaluation
- _____ Psychological Evaluation
- _____ Psychiatric Evaluation
- _____ Treatment Plan or Summary
- _____ Current Treatment Update
- _____ Medication Management Information
- _____ Presence/Participation in Treatment
- _____ Nursing/Medical Information
- _____ Toxicological Reports/Drug Screens
- _____ Educational Information
- _____ Discharge/Transfer Summary
- _____ Continuing Care Plan
- _____ Progress in Treatment
- _____ Demographic Information
- _____ Other _____
- _____ 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:

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to
Ruth Weinberg, MS, LPC 1726 Clarkson Street. Denver, CO 80218. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this consent expires on the following date: _____ or as otherwise indicated: _____

Conditions

I further understand that Ruth Weinberg MS, LPC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____

[Insert an explanation of the consequences, if any, of not signing this authorization, which will depend on the services being provided].

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to NATIONAL ASSOCIATION OF SOCIAL WORKERS DOCUMENT C2

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be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances: _____

If I request it, I will be given a copy of this authorization for my records.

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

Witness Signature

Date