

Northwest Counseling Associates

4257 Gabel Drive, Suite 3A • Fayetteville, AR 72703

AUTHORIZATION OF DISCLOSURE CONSENT FORM

Name: _____

Date of Birth: _____

I, _____, authorized to disclose to _____ and/or
(CLIENT, PARENT/LEGAL GUARDIAN) (YOUR THERAPIST AT NCA)

receive from _____
(Name/title of person(s) or organization(s) to which disclosure is to be made)

Address _____ Phone _____

The following identifying information from my records (specify extent or nature of information to be disclosed):

The specific information being requested consists of:

_____ Medical History	_____ Educational Evaluation
_____ Social History	_____ Master Treatment Plan
_____ Psychiatric Evaluation	_____ Master Treatment Plan Reviews
_____ Psychological Evaluation	_____ Discharge Summary

Other Pertinent Information: _____

The purpose of need for such a disclosure is: _____

This consent of disclosure may be revoked by me at any time except to the extent that action has been taken in reliance thereon.

This consent (unless expressly revoked earlier) expires 90 days after discharge.

PROHIBITION ON RE-DISCLOSURE: This information has been disclosed to you from records whose confidentiality may be protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than \$500, in case of a first offense, and not more than \$5,000 in the case of each subsequent offense.

Signature of Client

Date

Signature of Parent/Legal Guardian or Legal Representative

Date

Signature of Witness

Date