Zoe Counseling Services

Email: info@zoecounselingservice.com Tel: +1 (214) 466-7403 Fax: (214) 614-0476
www.ZoeCounselingService.com

Information Release Authorization

I, _____ authorize

(Service Recipient)

Zoe Counseling Services (Agency) to release information regarding services they provide to other agencies in accordance with 42 CFR Part 2, Confidentiality of Substance Use Disorder Patient Records. I understand that the purpose of this release is to assist with my/this service recipient's treatment by improving communication between professional service providers or agencies and the important individual(s) in my/the service recipient's life. To further this goal, I authorize this specific service provider to release the below-specified information regarding me/the service to the individual(s) listed below, and to receive information from them. I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these.

The information to be disclosed is marked by an X in the boxes below, and any items not to be released have a line drawn through them:

❑ Admission/discharge information ❑ Treatment plan ❑ Scheduled appointments

❑ Progress notes ❑ Medications

❑ Other: _____

This information is to be disclosed to these persons, who have the indicated relationship to me/the service recipient:

Name of person /agency:_____

Relationship: _____

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Name of person /agency:_____

Relationship: _____

I understand that I may revoke this release at any time, except to the extent that it has already been acted upon. This release will expire ❑ one year from this date, ❑ upon my discharge from treatment by this agency or by the person specified above, or ❑ under these circumstances: _____ .

_____ _____

Service Recipient or Authorized Representative Date

_____ _____

Agency Representative Date