MAKRINOS MENTAL HEALTH COUNSELING SERVICES, LLC

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, authorize Stanley Makrinos (MAKRINOS MENTAL HEALTH COUNSELING SERVICES, LLC) to release and/or receive the following information for me or my child/legal dependent's medical/clinical or financial record. This authorization includes release or receiving information concerning drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions and/or HIV status and related conditions and/or AIDS or AIDS-related conditions. Review of the records is also authorized.

Client Name: _____ Date of Birth: _____

Client's SS#: _____ Legal Guardian: _____

☐ **Release Information To:** ☐ **Request Information From:**

Name of Person/Agency: _____
Physical Address: _____
Phone and/or Fax: _____

The following information may be released or reviewed:

☐ Academic Records ☐ Assessment Registration ☐ Case Summary ☐ Closing Summary
☐ Diagnosis ☐ Doctor Orders ☐ Psychological Tests ☐ Treatment Plan
☐ Lab/Medical Results ☐ Psychological/Consultation ☐ Reports Collaboration ☐
☐ Drug/Alcohol Treatment
☐ Other _____
☐ All Information Listed Above

The above information is requested to be released and/or received for the following purposes only:

☐ Collaboration/Coordination of Treatment and/or:

_____

PROHIBITION OF REDISCLOSURE: This information is being disclosed and/or received from records where Confidentiality is protected by Federal Law including CFR42. Federal regulations prohibit you from making further disclosure of this information except with specific written consent from the person to whom it pertains. A general authorization for the release of clinical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute an alcohol or drug abuse patient. The information used or disclosed as a result of this authorization may be subject to redisclosure by the person or entity receiving such information, and thus is no longer protected by the state/federal privacy regulations, including the HIPAA Privacy Rule. The statement must be signed and dated, and may be revoked at any time to the extent action has been taken prior to revocation of this authorization. In order to revoke the authorization the individual/parent/legal guardian who authorized the initial release must do so in writing. This consent will expire two years after the termination of your treatment.

I understand that a standardized fee has been established for copies of medical/clinical records. Please inquire regarding these fees prior to requesting copies. A faxed copy or photocopy of this release may replace the original copy.

I hereby state that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure and/or release of the treatment records to the purpose and extent stated above.

_____ _____

Client Signature (or Parent (guarantor), if minor) ***Date Signed***