SUMMIT COUNSELING
Sarah West-Effland LCSW, LLC, Owner of Summit Counseling
618 SE 4th Street, Suite 104, Lee's Summit, MO 64063
Telephone: (816) 282-2161 / Fax: (816) 396-8380

Authorization to Release/Obtain Information

I hereby authorize Summit Counseling to *(choose one)*: ◯ Release to ◯ Obtain from

Name/Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

The following information from the medical records of:

Client's Name: _____ Date of Birth: _____

Date(s) of Treatment: _____

Information to be released: (Payment of a fee may be required before release of information.)

☐ Intake ☐ Progress Notes ☐ Treatment Plans ☐ Discharge Notes

☐ Verbal Communications ☐ Written Communications ☐ Testing/Assessments ☐ Other (specify) _____

The above information released is for the following purpose and that purpose only:

☐ Continuity of Care ☐ Legal Purposes ☐ Insurance Purposes ☐ Employer Requirement

☐ Personal Reasons ☐ Other (specify): _____

I understand that the information disclosed may contain testing or treatment information relating to Drug and/or Alcohol Abuse; HIV/AIDS virus; Sexually Transmitted Disease; Mental Health Treatment or Psychiatric Treatment.

I understand that I may, by placing my request in writing to Summit Counseling, revoke this authorization at any time, except to the extent that action has already been taken in reliance on this authorization. Unless revoked, this authorization will expire upon release of the information for the purpose stated above.

Summit Counseling may NOT require you to sign this authorization to receive treatment, and treatment will not be affected by the execution of this authorization, or refusal to sign this authorization.

I further authorize that a photocopy of this authorization form will be fully acceptable as an original, and that Summit Counseling may deny the release of protected health information if there is reason to believe this authorization has been altered or is not a true and accurate authorization initiated by the patient.

I understand that authorizing the disclosure of this protected health information is voluntary. I understand that any disclosure of information has the potential for unauthorized re-disclosure and the information may not be protected by federal privacy rules.

Except as provided under Federal Law 45 CFR 164.524, this information has been disclosed from records whose confidentiality is protected by Federal Law 42 CFR Part 2. The recipient of this information is prohibited from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.

Client Signature: _____ Date: _____

Print the name of Parent or Legal Guardian if the above client is a minor: _____

Your relationship to the Client as the person signing for him/her: _____

Parent or Legal Guardian Signature: _____ Date: _____

I desire a copy of this release for my records *(choose one)*: ◯ Yes ◯ No Initials of Signer: _____

Information has been released by: _____ Per authorization on: _____

For filling out this form electronically: Just type your name into the signature field(s) above to sign the form.