Authorization to Exchange Information

This authorization allows Community Counseling Associates to disclose, receive, or exchange confidential health information as authorized below.

Client Information

Client Name: ___________________________________ Date of Birth: _____________________

Address: ____

City: _________________________ State: _______ Zip: __________

Phone Number: ____

Authorization to Release Information FROM

Community Counseling Associates

Therapist/Counselor: _______________________________________

Address: ____

City: _________________________ State: _______ Zip: __________

Phone: ________________________________

Authorization to Release Information TO

Person / Organization Name: __________________________________

Relationship to Client: _______________________________________

Address: ____

City: _________________________ State: _______ Zip: __________

Phone: __________________________________

Email: ____

Information Authorized for Exchange

Please select the type of information to be released

☐ Treatment Summary

☐ Diagnostic Assessment

☐ Treatment Plan

☐ Attendance Verification

☐ Billing Information

☐ Progress Notes Summary

☐ Other: ______________________________

Method of Disclosure

☐ Phone

☐ Secure Email

☐ Personal Contact

Restrictions / Limitations on Disclosure

Please specify any information that should **NOT** be released

____

____

Purpose of Disclosure

Check all that apply

☐ Diagnosis

☐ Continuity of Care

☐ Treatment Planning

☐ Discharge Planning

☐ Further Evaluation

☐ Legal Purposes

☐ Insurance Claims

☐ School Coordination

☐ Other: ______________________________

Client Acknowledgments

Please initial each statement

_____ I understand that this authorization may be revoked at any time by providing written notice to Community Counseling Associates, except to the extent action has already been taken in reliance upon it. Upon revocation, further disclosure will cease immediately.

_____ This authorization will expire one (1) year from the date of signature unless otherwise specified below:

Expiration Date (optional): ________________________________

For disclosures related to insurance claims, this authorization will expire upon final claim determination or termination of coverage, whichever occurs later.

_____ I understand that I may be financially responsible for fees associated with record preparation, copying, or release as outlined in my informed consent agreement with Community Counseling Associates.

I further understand that if a subpoena requires counselor testimony or court appearance, a financial retainer may be required prior to the appearance date.

_____ I understand that records released under this authorization may contain sensitive information including:

- Mental health treatment information
- Drug and/or alcohol use, abuse, or treatment records
- HIV/AIDS-related information
- Communicable disease information

I specifically authorize release of this information where applicable.

_____ I understand that once information is disclosed to the authorized recipient, it may no longer be protected under federal privacy regulations and may be subject to redisclosure.

Federal law (42 C.F.R. Part 2) and Texas law prohibit unauthorized redisclosure of substance use treatment records without additional written consent unless otherwise permitted by law.

_____ I understand the contents of this authorization and voluntarily release Community Counseling Associates, its providers, employees, staff members, business associates, officers, and directors from legal responsibility or liability for disclosure made in good faith pursuant to this authorization.

Signature Authorization

Client Signature: ____ Date: ____________________

Printed Name: ____

If Signed by Legally Authorized Representative

Relationship to Client:

☐ Parent

☐ Legal Guardian

☐ Conservator

☐ Personal Representative

☐ Other ______________________________

****Office Use Only****

Processed By: ____

Date Received: ________________________ Date Released: _________________________

Method of Release: ____

Notes:____
____
____
_____