Horgan & Saling Counseling Services LLC

141 Wall Street, Princeton, NJ 08540
609-580-1075

Authorization for Release of Information

I, _____, whose date of birth is _____, authorize Horgan & Saling

Counseling Services LLC and my therapist _____ to disclose to and/or obtain from:

_____ the following information:

Description of Information to be Disclosed
(Client should initial each item to be disclosed.)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____ Nursing/Medical Information
_____ Toxicological Reports/Drug Screens
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____ Other _____
_____ Other _____

Purpose
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If other purpose, please specify:

_____

_____

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Horgan & Saling Counseling Services LLC at 141 Wall Street, Princeton, NJ 08540. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
Unless sooner revoked, this consent expires on the following date: _____ or as otherwise indicated:

_____

Conditions
I further understand that Horgan & Saling Counseling Services LLC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____

_____

Horgan & Saling Counseling Services LLC

141 Wall Street, Princeton, NJ 08540
609-580-1075

Forms of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Re-disclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances: _____

_____

I will be given a copy of this authorization for my records.

_____	_____	_____
Client Name	Signature	Date
_____	_____	_____
Parent/Guardian/Personal Representative	Signature	Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.). _____

_____Check here if client refuses to sign authorization

_____	_____	_____
Therapist Name	Signature	Date