

Framework Counseling & Consulting, LLC.
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Florence, AL 35633
(844)986-6946

Authorization for the Release of Information

Client Name: _____ Case #: _____

Name Relationship

Address

Phone Number Fax (if applicable)

I authorize the disclosure of:

- Admission
- Assessment
- Progress
- Discharged
- Recommendations
- Medications
- Form/Letter
- Appointment Information
- Other information as deemed appropriate by staff
- Other _____

The purpose for this disclosure:

- Continuity of Care
- Case Coordination
- Determine Eligibility of Benefits
- My Personal Records
- Legal
- Bring to/pick up client for appointments
- Pick up medications Schedule/Confirm/Cancel Appointments
- Family contact
- Emergency contact
- Other _____

I may revoke my consent for disclosure of any information concerning my case at any time, except to the extent that action has already been taken. This consent agreement will automatically expire at the earliest time as indicated as date of revocation. I further understand the agency and/or professional receiving this information will not further release this information without my consent.

Date of Invocation: _____

Date of Revocation: _____

Privileged date of Revocation (if applicable): _____

Witness/Title: _____ Date: _____

Client Signature: _____ Date: _____

PROHIBIT DISCLOSURE OF INFORMATION CONCERNING CLIENT IN ALCOHOL OR DRUG ABUSE TREATMENT: This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from the records protected by Federal confidentiality rule (42 CFR, Part 2). The Federal guidelines prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal guidelines restrict any use of the information to criminally prosecute any alcohol or drug abuse client.