



Pioneer Counseling Center

AUTHORIZATION OF DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient Name: _____ Date of Birth: _____ Social Security #: _____

I, _____ authorize the information specified below to be disclosed as follows:

From: PIONEER COUNSELING CENTER
To: Name of Person: _____
Organization: _____
Address: _____

Disclosure shall be limited to the following specified information contained in my records and/or obtained during the course of my treatment by Pioneer Counseling Center (Check of YES or NO for each item):

Table with 3 columns: Item, YES, NO. Rows include Assessment and Diagnostic Summaries, Psychiatric Evaluations, Medication Regime, Laboratory Information (Excluding HIV), Attendance Record, Progress Note: Specify Dates, Verbal Exchange, Discharge Summary, and Other: Please Specify.

If information in my records pertains to HIV or AIDS, I expressly do _____, do not _____, authorize Pioneer Counseling Center to disclose such information pursuant to this authorization. _____ Not applicable PLEASE INITIAL _____

I am aware of the confidential and/or privileged nature of the information being disclosed, and understand the benefits and/or disadvantages of disclosing such information. I hereby release Pioneer Counseling Center and its affiliates, representatives, and assigns from all legal liabilities that may result from the release of this information.

I acknowledge that I have the right to revoke this authorization at any time, by sending written notification to the medical records department of Pioneer Counseling Center. I understand that a revocation is not effective if Pioneer Counseling Center already has taken actions in reliance of the authorization.

I am requesting that this information be disclosed for the purpose(s) of: _____.

This authorization shall be in full force and effect until _____. If no expiration date is provided, this authorization shall expired one hundred eight (180) days after the date on which I signed below.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient, and may no longer be protected by federal and state privacy laws and regulations.

I understand that Pioneer Counseling Center will not condition my treatment, payment, or enrollment or eligibility for benefits on whether I provide this authorization.

Client signature/Legal guardian signature (if applicable)

Date

Legal guardian name (print)

Indicate Authority to Sign

Witness signature

Date