

**Release of Information Consent**  
**Granite City Counseling, LLC**

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I authorize Granite City Counseling, LLC at 818 2<sup>nd</sup> Street South, Suite 180, Waite Park, Minnesota 56387 to:

Obtain information from       Disclose information to       Exchange information with

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social/psychological assessment       Psychological testing  
 Diagnosis       Discharge summary  
 Progress notes       Summary of treatment contacts  
 Treatment plan       Dates of treatment  
 Medical reports       Psychiatric assessment  
 Chemical dependency treatment/evaluation       School records  
 Other (specify) \_\_\_\_\_

The above information will be used for the following purposes:

Planning appropriate treatment or program       At the request of the individual  
 Continuing appropriate treatment or program       Other (specify) \_\_\_\_\_  
 Treatment consultation

This authorization shall remain in effect until episode of care ends.

This authorization shall remain in effect for one year from the date signed below.

This authorization ends in less than one year. Date of expiration is \_\_\_\_\_.

Dates of services requested:

Complete       Present episode of care       Past seven years of medical records

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

A photocopy is as valid as the original copy bearing my signature.

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/guardian/personal representative (if applicable)

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness (if client is unable to sign)

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_