Release of Information Consent

Granite City Counseling, LLC

Client Name: _____ DOB: _____

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

X Obtain information from ___ Disclose information to ___ Exchange information with

Name: _____

Address: _____ City:_____ State:_____ Zip: _____

X Social/psychological assessment X Psychological testing
X Diagnosis X Discharge summary
X Progress notes X Summary of treatment contacts
X Treatment plan X Dates of treatment
__ Medical reports ___ Psychiatric assessment
X 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
X Continuing appropriate treatment or program ____ Other (specify) _____
____ Treatment consultation

___This authorization shall remain in effect until episode of care ends.
X 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 X 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: _____/____/_____