RELEASE AND/OR OBTAIN INFORMATION FORM

I,_____, AUTHORIZE BAY AREA CHRISTIAN COUNSELING
(Name of Client/Legal Guardian)

TO RELEASE/OBTAIN INFORMATION CONCERNING MY TREATMENT TO/FROM

_____

For Client _____ Date Consent Initiated:_____

REGARDING THE FOLLOWING INFORMATION:

_____Initial Interview _____Psycho-Social History

_____Counselor's Notes _____Discharge Summary

_____Medical History, Physical Exam, _____Disability Report or
Forms Laboratory Reports

_____Other (Specify): _____

I WOULD LIKE THIS INFORMATION FORWARDED BECAUSE:

_____It will contribute to a comprehensive treatment plan for me.

_____It will provide information to my insurance company r third party payees as needed for billing.

_____Other reasons (Specify): _____

I understand that my treatment records are protected under Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for by Regulations. I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it (e.g. probation, parole, court ordered, etc.). I also understand that this consent expires automatically at the completion of the disclosure unless specifically provided for the following date, event or condition, which marks the expiration of consent:

_____ _____
Client/Legal Guardian Signature Date

_____ _____
Witness Signature Date

PROBATION OF REDISCLOSURES

This information has been disclosed to you from records whose confidentiality is protected by Federal Law, Federal Regulations (42CFR, Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical information is NOT sufficient for this purpose.