Rhonda “Roni” Lanier, M.S., LPC, CDC I

4400 Business Park Blvd.

Building B, Suite #11

Anchorage, AK 99503

(907) 223-4374

# Authorization for Release of Information

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

 (Name of client whose information is being released)

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Client  Parent  Legal Guardian hereby authorize Arctic Owl Counseling and/or Rhonda “Roni” Lanier, MS, LPC, CDC I to: \_\_\_\_ Release To: \_\_\_\_ Obtain From:

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

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following written and verbal information (please initial)

\_\_\_\_\_ Admissions/Intake Summary \_\_\_\_\_ Medication Records \_\_\_\_\_ Psychosocial Assessments \_\_\_\_\_ Psychiatric Evaluation

\_\_\_\_\_ Psychological Test Results \_\_\_\_\_ Treatment Plan \_\_\_\_\_ Discharge Summary \_\_\_\_\_ Substance Abuse Assessment/Treatment

\_\_\_\_\_ School Records (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PURPOSE OF INFORMATION (please initial)

\_\_\_\_\_ Treatment Planning \_\_\_\_\_ Personal Use \_\_\_\_\_ Continued Treatment \_\_\_\_\_ Legal Use

\_\_\_\_\_ Coordinate Treatment \_\_\_\_\_ Employment Assistance \_\_\_\_\_ Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment, payment, enrollment, or eligibility for benefits. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. I understand that the information released may include information regarding assessment, evaluation, and treatment. If I have questions about disclosure of my health information, I can contact Arctic Owl Counseling, LLC at (907) 223-4374. I understand that I have a right to revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire 90 days after treatment has ended or on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal Regulations (42 CFR Part 2) prohibiting you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. Federal Regulations state that any person who violates any provision of this law shall be fined not more than $500, in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

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Client Signature (Optional for Minors/Adults with Guardians) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relative/Guardian/Authorized Person Printed Name Relationship to Client

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness