brightside
counseling services, llc.

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Consent for Release of Information

I, ____________________________________ hereby authorize the exchange of information between the administrative or clinical staff of Brightside Counseling Services, LLC to use or disclose the protected health information (PHI) described below to the person and for the purpose set forth below.

1. The person(s) or entity to receive the PHI:

   Name: ____
   Address: ____
   ____
   Phone: ____

2. The type of information (PHI) which I authorize to be used or disclosed is:

❑Medical/Mental Health Records ❑Evaluations ❑Treatment Plan
❑Mental Health Treatment Summary ❑Diagnosis ❑Psychological/Medical Test Results
❑Course Treatment ❑Other ____

3. For the purpose of:

❑Ongoing Treatment ❑Evaluation ❑Consultation
❑Coordination of Care ❑Medical Care ❑Legal Issues
❑Health Benefit Utilization ❑Transfer ❑Other _______________________

4. Exceptions: ____

This authorization is in effect until either the following date or event: _____________________, at which time this release will expire. I understand that I may revoke the authorization, in writing, at any time, by notifying the releasing organization, but my revocation will not affect any releases made or other actions taken before the date of my revocation.

I understand that the designated information about me may be sent by mail or delivery service, transmitted by fax, electronic mail or electronic file transfer mechanism, or exchanged verbally unless otherwise restricted by me. I agree that a photocopy or fax of this authorization shall be as valid as the original.

I understand that I have the right to request restrictions on uses and disclosures of protected health information. Brightside Counseling Services, LLC is not required to agree to this request, but if we do agree, the restriction is binding and will be honored. I understand that Brightside Counseling Services, LLC has a formal Notice of Privacy Practices containing additional information and that I may review the notice prior to signing the consent. The Notice of Privacy Practices may change from time to time and I may obtain a revised notice from my therapist.

I hereby release all parties stated herewith from any liability resulting from the release of this information.

______________________________ ____________ ________________________________ ____________
Signature of Client (ages 15 and older) Date Parent/Guardian or Personal Representative Date

___________________________________ ______________ ____
Therapist or Witness Signature Date Relationship/ Authority of Personal Representative

NOTICE TO RECIPIENT: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. It may also be covered under 42 CFR Part 2, "Confidentiality of Alcohol and Drug Abuse Patient Records." Federal regulations prohibit you from making any further disclosure of this information except with 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 or other information is not sufficient for this purpose.

This authorization has been revoked by the client (letter in file) effective: ____

Recorded by: ____