O'Leary Counselling, LLC

Release of Information

Please Complete and email to info@olearycounseling.com or print and bring with you to your next session. If you are unable to print or complete and e-sign this document on your home computer your therapist can print it at your request and you can complete it at your next scheduled appointment.

I _____(Your Name) hereby authorize the release and disclosure of the following clinical and/or therapeutic records belonging to _____(name of client) for the following purpose(s):

Please initial next to all that apply:

____ Authorization to release information regarding counseling and therapy care and treatment.

____ Authorization to release information held under the Drug Office and Treatment Act of 1972 (PL- 92255) and the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act Amendments of 1974.

____ Authorization to release information related to Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)

Specific information to be released (please initial all that apply) :

____ Assessments and evaluations

____ Psychosocial history

____ Continued care and treatment Discharge summary

____ Attendance/Correspondence

_____Billing information

I authorize the release of information between O'Leary Counseling, LLC and: (**Do not put client's name here this is where you put the organization or person you would like to authorize us to share information with**)

Name* _____

Organization/Business/Healthcare Practice* _____

Email * _____

Phone # *_____ Fax # (optional) _____

Revocation/Expiration: This Release of Information is subject to revocation by the undersigned at any time except to the extent that information has already been disclosed based on authorization contained herein. Unless further limited by a date stated here (below) this Release of Information will automatically expire after a period of 180 days from the date signed. I have the right to receive a copy of this Release of Information upon my request.

Revocation/Expiration Date: _____

Client Name: *_____ Date_____

Client Signature*_____ Date _____

Parent/Guardian Name *_____Date _____

Parent/Guardian Signature*_____Date_____

Therapist Signature*_____Date_____