Bethlehem Counseling Associates

2045 Westgate Drive, Suite 304
Bethlehem, PA 18017
(610) 865-8177
www.bethlehemcounselingassociates.com

RELEASE OF INFORMATION AUTHORIZATION FORM

This form when completed and signed by you, authorizes Bethlehem Counseling Associates to release protected information from your clinical record to the person you designate.

I/We _____ do hereby consent and authorize
(Client Name)

_____
(Therapist Name)

_____ To release information to: _____ to secure information from:

Name _____

Agency/Doctor's Office _____

Address _____

City _____ State _____ ZIP _____

Phone _____ FAX _____

For the purpose of: _____treatment planning _____other _____

The information to be released is:

_____Treatment Plan _____Termination Summary
_____Psychological Evaluation _____School Records
_____Progress Reports _____Recommendations

Other (Please Specify) _____

I/We understand that this authorization shall remain in effect for one (1) year unless otherwise noted. I/We also understand that this authorization can be revoked (except to the extent that action has been taken) at any time by dated, written communication to Bethlehem Counseling Associates.

I/We understand that BCA generally may not make the signing an authorization for a third party a condition of providing continued psychological services.

I/We understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian or Authorized Representative Date

_____ _____
Signature of Witness Date