BIRCH COUNSELING
Growth.Hope.Resilience.

Release of Information

Client Name:_____ DOB:_____ ID Number:_____

I, _____[parent/guardian or client if not a minor) authorize

Name:__Birch Counseling_____
Address:__3325 Durham-Chapel Hill Blvd, Suite 205_____
City, State, Zip:___Durham, NC 27707_____ _____

to disclose to and/or obtain information by mail, fax or email from:

Name:_____
Address:_____
City, State, Zip:_____

Description of Information to be Disclosed
(Patient/Client should initial each item to be disclosed.)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ All of the above

_____ Presence/Participation in Treatment
_____Nursing/Medical Information
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____Psychotherapy Notes
_____Other_____

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment, and when appropriate, coordinate treatment services. This authorization is freely given unto Birch Counseling with the understanding that:

1. Any and all records are confidential and protected under state and federal confidentiality regulations and cannot be disclosed without prior authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this this orginial.
3. By signing this release, I do not give permission for the receiver of this information to re-disclose information to any third party and Birch Counseling cannot guarantee the privacy of information after it has been released.
4. I understand I may refuse to sign this consent and that my refusal will not affect my ability to obtain treatment.
5. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or for less time, if noted below. The revocation must be in writing.
   Authorization End Date (if other than 1 year): _____

_____

Client or Guardian Date

Megan Hamilton, MA LPC Date