Abundant Living
Psychological and Coaching Services for Children and Adolescents

Release of Information

I, (Name of Client) _____, Client Date of Birth _____ (Today's Date) _____, authorize the staff at Abundant Living Psychological and Coaching Services for Children and Adolescents, PLLC to release information on my health information that may contain mental health, developmental disability and drug and/or alcohol treatment records to, and obtain such information from

_____

_____

(Name/ Address/ Program and/or Title)

Purpose:

- ☐ Ongoing diagnosis
- ☐ Treatment Planning
- ☐ Social, vocational, fiscal, or educational planning
- ☐ To report attendance at EAP assessment
- ☐ Legal
- ☐ Application for health benefits
- ☐ Disability determination
- ☐ To obtain payment of a health benefits claim

Type of Information:

- ☐ Dates of hospitalization
- ☐ To report attendance at EAP assessment and agreement to follow through
- ☐ Psychiatric, social, psychological and other allied health evaluation
- ☐ Diagnosis
- ☐ School Reports
- ☐ Reports of Progress and treatment
- ☐ Medical history and medications

Redisclosure Notice: I understand that if a recipient of the health information is not governed by federal and state confidentiality laws, the health information disclosed as a result of this authorization may be redisclosed by the recipient and no longer be protected by such laws.

Expiration Date: This release is good until the following date (s)/ events: ONE year and ONE month. If no date is specified, this release will expire one (1) year and one (1) month from the date signed.

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Your rights with respect to this release

- Right to inspect or copy the health information to be used or disclosed for this release: I understand that I have tot right to inspect or copy the health information I have authorized to be used or disclosed by this release.
- Right to receive a copy of this release: I understand that if I agree to sign this release, which I am not required to do, I shall be provided a copy of the signed copy of this release.
- Right to refuse to sign: I understand that this release is voluntary and that I may refuse to sign this release. Unless allowed by law, my refusal to sign this release will not affect my/ Client's ability to obtain treatment, receive payment or eligibility for benefits.
- Right to revoke release: I understand that written notification must be presented to the staff of Abundant Living Psychological and Coaching Services for Children and Adolescents in order to cancel this release. I understand that my withdrawal not be effective as to uses and/or disclosures of my /client's health information (i) already made in reliance on this release by the person (s) and/or organization (s) listed above or (ii) if this release was obtained as a condition of obtaining insurance coverage, to the extent that such person (s) and/or organization (s) have the right to contest a claim under the policy pursuant to which such coverage is provided, or the policy itself.

I have had an opportunity to review and understand the consent for release of information. By signing this release, I am confirming that it accurately reflects my wishes.

Signature of Client	Signature of Legal Representative
Date	Authority to Act for Client