Courage Counseling

Lindsy Rilinger, LSCSW
729 ½ Massachusetts St. #214
Lawrence, KS 66044
P: 785-633-2743 - F: 785-640-8400
lindsy@couragecounselingks.com

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I ____, D.O.B. __________authorize Lindsy Rilinger, LSCSW, to:

_____ release to:
_____ obtain from:
_____ exchange with:

NAME:____

ADDRESS:____

PHONE:____

FAX:____

the following information pertaining to myself: (Initial)

_____ treatment summary
_____ history/intake
_____ diagnosis
_____ psychological test results
_____ psychiatric evaluation/medication history
_____ dates of treatment attendance
_____ other (specify) ______________________________

for the purpose of: (Initial)

_____ Continuity of care
_____ Disability determination
_____ Legal proceedings
_____ Financial
_____ other (specify) ______________________________

Via: (Initial)

_____ mail
_____ Verbal (in person or vial phone)
_____ Electronic (fax, e-mail

Courage Counseling

Lindsy Rilinger, LSCSW
729 ½ Massachusetts St. #214
Lawrence, KS 66044
P: 785-633-2743 - F: 785-640-8400
lindsy@couragecounselingks.com

READ CAREFULLY

My signature below acknowledges my understanding of the following:

- I understand that medical/behavioral health records are confidential. By signing this authorization I am allowing the release of information, including any substance abuse information, to the agency or person specified above. Transfer of the information released above to persons or agencies not specified is prohibited by law.
- I understand that signing this authorization is not a condition of receiving treatment here.
- This authorization includes both information presently compiled and information to be compiled during the course of the client's treatment at this agency.
- I understand that there is a potential for the information disclosed to be subject to redisclosure by the recipient and no longer protected by this law.
- This consent is subject to revocation by the undersigned at any time by completing the notice of revocation at the bottom of the page.
- This consent to release information (unless revoked earlier) will automatically terminate one year from the date of signing, or six months from the date of signing if the purpose is for other than treatment.
- Specify any special conditions, date, events that would result in revocation: ____________________________________
- I understand that I have the right to receive a copy of this authorization and to request to see or copy the information disclosed.
- This authorization to release information is subject to the following restrictions: ____________________________________

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

____

Signature of Client **Date**

____

Signature of Legal Guardian/Custodian **Date**

____

Signature of Witness **Date**