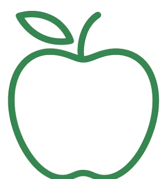

Green Apple Counseling, LLC
1500 10th Ave South
Great Falls, MT 59405
Tel. 406.866.0350
Fax. 406.403.0263

AUTHORIZATION/ REQUEST TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

I, (client name) ______________________________ (Date of Birth) ____________

If a minor, Parent's name: ______________________Relationship: _____________

Hereby authorize: _______________________________________

Phone Number: ________________________ Fax Number: __________________

To send and receive information of records for Assessment, Treatment Process, Psychotherapy and/or Discharge Planning, etc. **to GREEN APPLE COUNSELING, LLC.**

The information to be disclosed is marked by a check below:

____Behavior programs ____Case/Progress notes ____Psychological reports

____Mental health Evaluation ____Treatment plans ____Entire record

____ Chemical Dependency Evaluation _____ Court Documents ____Other ______________

This consent will expire (Initial one):

_____1 year from date on which it is signed

_____ Other Date ______________

HIV related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: _________do not release. I have had this form explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take cack this consent at any time within 90 days, by giving written notice of revocation to Green Apple Counseling, LLC, except to the extent an action based on this consent has already been taken.

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

____

Client or Parent/Representative Signature *Date*

____

Green Apple Counseling, LLC Signature *Date*

Notice: * Protected health information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy law. *Green Apple Counselling, LLC may Not condition treatment, payment, enrollment, or eligibility for benefits contingent on signing this form.