Olive Tree Counseling, Inc.

1981 E Palmer-Wasilla Hwy, Suite 220, Wasilla, AK 99654
Phone: (907) 357-6513 | Fax: (907) 357-6514

Authorization for the Disclosure of Information

Client's Full Name | *Date of Birth*

I authorize Olive Tree Counseling, Inc., to: _____ **the following party:**

Party's Name / Organization | *Party's Phone Number*

Address | *City / State / ZIP* | *Party's Fax Number*

For the following reason: ☐ Coordination of Treatment ☐ Continuation of Treatment ☐ Court Order
☐ Other (elaborate): _____

The information I authorize Olive Tree Counseling, Inc. to disclose to or request from the above (Initial all that apply):

_____ Diagnosis (*initials*) _____ Therapist Notes (*initials*) _____ Financial (*initials*) _____ Attendance (*initials*)

_____ Summary of Care (*initials*) _____ Other (specify): _____ (*initials*)

Minors

_____ (*initials*) I acknowledge the client listed above is a minor and attest that I am the parent or court-appointed legal guardian of said minor, and I have legal authority and rights to make decisions on his or her behalf. I understand and agree that Olive Tree Counseling, Inc. reserves the right to refuse to release information on a minor where compliance is not required by law.

Acknowledgment and Agreement

_____ (*initials*) I have read, had explained to me, and fully understand this Authorization for the Disclosure of Information, including the nature of the records, their contents, and the consequences and/or implications of their release. This authorization is an entirely voluntary decision on the part myself as signed above. I understand that my records are protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and cannot be disclosed unless permitted by the HIPAA regulations and/or other applicable State and Federal laws and further protected by CFR Part 2, The Federal Regulations Governing the Confidentiality of Substance Abuse Records, and Olive Tree Counseling, Inc. will not disclose my information without my written authorization. I understand that I may revoke this consent in writing at any time except to the extent that action based on this consent has already been taken. I am aware that this consent expires automatically upon fulfillment of the purposes stated. I understand that treatment, payment, or other benefits are not a condition upon my signing of this authorization and am entitled to a copy for my own records.

Client's Signature | *Date*

Parent/Guardian/Representative's Signature | *Date*

Therapist's Signature | *Date*