Resolution Services
Counseling and Wellness Center
Office of Vivian Patton
401 E Northern Lights Blvd. STE 205
Anchorage, Alaska 99503
907-770-7769 phone, 907-770-7634 fax

____
Last Name First Name Middle Initial Date of Birth

____
Address

I, ____,
hereby authorize the release and disclosure of the following clinical and/or therapeutic records for the following purpose(s):

[ ] Authorization to release information regarding counseling and therapy care and treatment.

[ ] Authorization to release information held under the Drug Office and Treatment Act of 1972 (PL-92255) and the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act Amendments of 1974. I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

[ ] Authorization to release information related to Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

Release to:

Name of Provider/Person: ____

Address: ____

Phone: ____________________

Specific information to be released (client's initials to approve release):

_______ Assessments and evaluations (specify:)

_______ Entire mental health record

_______ Summary of treatment

______ Psychosocial history

______ Discharge summary

Correspondence (specify): ____

Other (specify): ____

____

Purpose(s) for which information is to be released (check all that apply):

_______ continuity of care

_______ consultation

______ referral

______ personal

_______ other (please describe): ____

I do not authorize the release of the following information:

____

Revocation/Expiration: I understand that I may revoke this authorization in writing at any time, except for actions that have already been taken prior to this request. (Forms are available from the therapist.) This authorization will expire ____ days after the signature below. This agency is hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.

Signature:____ Date: ____/____/____

Witness Signature: ____ Date: ____/____/____