Release of Information Consent

Client Name: _____
Address: _____City: _____State: _____Zip: _____
Phone: _____ DOB: _____

I, _____, authorize{***Bridgestone Consulting Services, LLC*** }to:
_____(send) _____ (receive) the following _____ (to) _____from

Name: _____Phone#_____
Address: _____

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR "PSYCHOTHERAPY NOTES".

____ Progress Reports
____ Treatment Plan(s)
____ Entire record, except progress notes
____ Psychotherapy Notes
____ Evaluation/Assessment
____ Attendance Records
____ Other, specify _____

The above information will be used for the following purposes:
____ Planning appropriate treatment or program
____Continuing appropriate treatment or program
____ Determining eligibility for benefits or program
____ Case Review ___ Updating files
____ Court order
____ Other (specify) _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under this guideline they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship the to client (please circle): Self Parent/legal guardian Other

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Signature: _____Date: _____
Client/Parent/Guardian/personal representative

Signature: _____Date: _____
Witness (if client is unable to sign)