ASPIRE
COUNSELING GROUP

871 Washington Street
Raleigh, NC 27605
www.AspireGroupNC.com
919-229-9834 office • 919-747-4269 fax

Authorization for Release of Information

I, _____ [Insert Name of Client], whose Date of Birth is _____, authorize _____ of Aspire Counseling Group, PLLC, to disclose to and/or obtain from: _____ [Insert Name of Person or Title of Person or Organization] the following information:

Description of information to be disclosed

Client should ✓ and initial each item to be disclosed:

____ ☐ Assessment
____ ☐ Diagnosis
____ ☐ Psychosocial Evaluation
____ ☐ Psychological Evaluation
____ ☐ Psychiatric Evaluation
____ ☐ Treatment Plan or Summary
____ ☐ Current Treatment Update
____ ☐ Medication Management Information
____ ☐ Presence/Participation in Treatment
____ ☐ Nursing/Medical Information
____ ☐ Educational Information
____ ☐ Discharge/Transfer Summary
____ ☐ Continuing Care Plan
____ ☐ Progress in Treatment
____ ☐ Demographic Information
____ ☐ Psychotherapy Notes*
*(*Cannot be combined with any other disclosure/authorization)*
____ ☐ Other_____
____ ☐ Other_____

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If the purpose is other than marketing, sale of information, research or as specified above, please specify:

Marketing

☐ If the purpose of this disclosure is for marketing purposes, please check this box and set forth the financial remuneration amount received by Aspire Counseling Group, PLLC, in exchange for disclosing the information.
$_____

Sale of Information

☐ If the purpose of this disclosure is for the sale, license to use or lease of the information, please check this box.

Research

☐ If the purpose of this disclosure is for research purposes, please check this box and identify the current and future research studies as well as whether each research study is conditioned upon execution of this authorization and individual's ability to opt into each study.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Christine Gerhard Dicks, LCSW, Privacy Officer, Aspire Counseling Group, PLLC at 871 Washington Street, Raleigh, NC 27605. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated:

Conditions

I further understand that Aspire Counseling Group, PLLC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

If requested, I will be given a copy of this authorization for my records.

Please note that a typed name does not constitute a legal signature.

_____

Signature of Client Date

_____

*Signature of Parent, Guardian or Personal Representative Date

**If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.)*

☐ Check here and sign below if patient/client refuses to sign authorization:

_____

Signature of Staff Witness Date