



Green Apple Counseling, LLC
 1500 10th Ave South
 Great Falls, MT 59405
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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:

- | | | |
|---|--|--|
| <input type="checkbox"/> Behavior programs | <input type="checkbox"/> Case/Progress notes | <input type="checkbox"/> Psychological reports |
| <input type="checkbox"/> Mental health Evaluation | <input type="checkbox"/> Treatment plans | <input type="checkbox"/> Entire record |
| <input type="checkbox"/> Chemical Dependency Evaluation | <input type="checkbox"/> Court Documents | <input type="checkbox"/> 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.