



Valliere & Counseling Associates, Inc.

Forensic Treatment Services

RELEASE OF INFORMATION

Client's Name: _____ DOB: _____

This form authorizes a release of information to Valliere & Counseling Assoc./Forensic Treatment Services regarding my treatment or involvement with:

This form authorizes a release of information from Valliere & Counseling Assoc./Forensic Treatment Services regarding my treatment or evaluation to:

The information to be released is limited to:

- | | | |
|---|--|---|
| <input type="checkbox"/> Attendance | <input type="checkbox"/> Urine Screen results | <input type="checkbox"/> Progress Summaries |
| <input type="checkbox"/> Aftercare Plan | <input type="checkbox"/> Referral Information | <input type="checkbox"/> Evaluations/Assessment |
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Statement of Prognosis | <input type="checkbox"/> Recommendations |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Telephone Contact |
| <input type="checkbox"/> Diagnostic Information | <input type="checkbox"/> Inclusion in Family Therapy/Collaboration | |
| <input type="checkbox"/> Polygraph Report | <input type="checkbox"/> _____ | |

This information is to be supplied for the purpose of:

- fulfilling probation/parole stipulation or requirements
- fulfilling court order
- referral/aftercare treatment
- reimbursement for treatment
- case management/treatment/treatment planning/placement planning
- _____

I understand that this authorization to release information will remain in effect for 1 year from the date of my signature (/ /). Initial: _____ or that this release is ongoing until there is no longer a need for contact (e.g. probation expires, new insurance company) Initial: _____. I may revoke this authorization in writing at any time, except to the extent that information has been disclosed prior to my revocation or if there are limits of revocation set by court order or mandated treatment. A copy of this form may be used instead of this original. I understand the contents of this release.

Signature: _____ Date: _____

Witness: _____ Date: _____

Client has accepted _____ or rejected _____ a copy of this consent form.

All information released will be handled confidentially, in compliance with the Federal Regulation 42 C.F.R., 2.31 and 2.35, and 4 PA Code 255.5, PA Act 143. Information from other facilities, persons, organizations provided will not be re-released to fulfill requests within this consent, unless expressly permitted (42 CRF, Part 2). A general authorization is not sufficient.