Eberhart Counseling, LLC
Ellen Eberhart, LCMHC, MLADC

Authorization for Release of Confidential Information

I authorize Ellen Eberhart, LCMHC, MLADC, to:

_____ Disclose Information to _____ Exchange Information With
_____ Obtain Information From

The following Individual/Organization: _____
Name of Individual/Organization

_____
Mailing Address Phone/Fax

Regarding Protected Health Information from the records of the following individual:

_____
Print Name DOB

Information pertaining to (check all that apply):
_____ Presence in treatment including admission/discharge dates
_____ Intake Assessment/Diagnoses _____ Treatment/Service Plan
_____ Discharge Summary _____ Other (specify):_____
_____ Substance Use/Abuse assessment/treatment information*

Purpose of disclosure:
_____ Coordination of services _____ History/Assessment
_____ Family communication _____ Other (specify): _____

Specify time period for which information is to be released:

_____ From _____ To _____ _____ All dates of service

_____ _____
Signature of Client/Legal Representative Date

_____
Relationship to Client

_____ _____
Witness Date

SUBSTANCE ABUSE RECORDS REDISCLOSURE:I understand that my records may be protected by Federal Confidentiality Rules (42 CFR Part 2), The federal rules prohibit further disclosure of this information without my written consent or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information in a criminal investigation or prosecution of any alcohol and/or drug abuse or dependent patient.