AUTHORIZATION for the Release of Information

____
Individual's Full Name

____ ____
Address **Date of Birth**

____ ____
City, State Zip Code **Telephone Number**

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:
   ___Beth Glisczinski, MA, LPCC____
2. The following person (or class of persons) may receive disclosure of protected health information about me:

   ____
   His/her/its Name

   ____
   Address

   ____
   City, State Zip Code
3. The specific information that should be disclosed is (please give dates of service if possible):
   ___Behavioral Health Assessment Information (dates ______________________________)
   ___Behavioral Health Treatment Information (dates ______________________________)
   ___Educational Records/Information (dates ______________________________)
   ___Information about Medications (dates ______________________________)
   ___Information about Physical Health Care (dates ______________________________)
   ___Social and/or Family History (dates ______________________________)
   ___Other: ____

   UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
   YES, DISCLOSE THIS INFORMATION *______________________________________
   NO, **DO NOT** DISCLOSE THIS INFORMATION * ________________________________
4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying Beth Glisczinski, MA LPCC in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for ____.
7. This authorization expires on _____________, 200___, OR 45 days after the end of my treatment services.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for copies; if not, then your copies will be mailed along with an invoice.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

____	______________________________	__________________________________
Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth or**

OR, if applicable –

______________________________________	______________________________	__________________________________
Signature of Guardian*	**Date of Signature**	**Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signator.