CREEKSIDE
COUNSELING
PROFESSIONAL MATTERS

CREEKSIDE COUNSELING LLC.
26400 Kuykendahl Rd. STE C180 The Woodlands, TX 77375
Office: 281.849.9691 | Fax: 281.849.3870

AUTHORIZATION OF RELEASE OF CONFIDENTIAL INFORMATION

CLIENTS NAME: _____Date of Birth: _____

Requesting Entity: Creekside Counseling LLC.
26400 Kuykendahl Rd. STE C180
_____
Street Address
The Woodlands, TX 77375
_____
City/ State/ Zip
281.489.3870 281.849.9691
_____/_____
Fax Phone

Releasing Entity:
_____
Street Address
_____
City/ State/ Zip
_____/_____
Fax Phone

_____ (initial) I authorize this release to be reciprocal between the two parties.

INFORMATION AUTHORIZED FOR RELEASE

_____ ☐ Psychological/Mental Health Evaluations/Reports
_____ ☐ Psychiatric Evaluations/Reports
_____ ☐ Physical / Medical Records / Med. List
_____ ☐ Lab Results
_____ ☐ Radiology Reports (CT/MRI)
_____ ☐ Emergency Reports
_____ ☐ Social History
_____ ☐ Vocational/ Work Information
_____ ☐ Discharge Summary (ies)
_____ ☐ Verbal Information
_____ ☐ Information re **HIV Status**
_____ ☐ Substance Abuse History

_____I hereby authorize the above information to be released to the party I have indicated for the purpose of:
continuity of care _____ other: _____
I retain the right to revoke this authorization in writing prior to the expiration date below.
_____*If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (CFR 42 Part 2) prohibiting you from making further disclosure of this information without the specific written authorization of the person to whom it pertains or as otherwise permitted by CRF 42 Part 2. A general authorization for the release of medical or other information if held by another party is not sufficient for the purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Treatment may not be conditioned on obtaining the authorization if that is prohibited by the HIPPA Privacy Rule. The information disclosed pursuant to this authorization may be subject to re-disclosure by the designated recipient, and subsequently no longer protected by the HIPAA Privacy Rule.*

_____ _____
Signature of Client or Client's Designee *Designee's Relationship to Client*

_____ _____ *TO* _____
Witness *Date Authorized* *Date Authorization ends*