# Rape Response Counseling Services
# Release of Information

**Client/Patient full name: _____ (Date of Birth) _____/_____/_____/**

I, (full name) _____ (Client or legal representative of client) authorize Rape Response Counseling Services to: **Obtain Information From ____** **Disclose Information To ____**

Name and Address of Organization:
_____
Phone Number
_____
Fax Number
_____

**1. Information Related to Treatment May Include: (check all that apply)**

- ☐ Assessment/Diagnosis/Family History
- ☐ Psychological Testing/Consultation
- ☐ Treatment History
- ☐ Other (please specify): _____
- ☐ Treatment Summary and Recommendations
- ☐ Medical Information/Prescribed Medications
- ☐ Substance History and/or Treatment

**2. I authorize the release of my complete health record with the exception of the following information:**

- □ Mental health records
- □ Communicable diseases (including HIV and AIDS)
- □ Alcohol/drug abuse treatment
- □ Other (please specify): _____

**3. This authorization for release of information covers the period of healthcare from:**
a. _____ to _____ OR b. all past, present, and future periods.

**4. This authorization shall be in force and effect until** _____ (date or event), at which time this authorization expires.

**5. I understand that I have the right to revoke this authorization**, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

**6. I understand that my treatment, enrollment, or eligibility for benefits will not be conditioned** on whether I sign this authorization.

_____
Signature of patient or legal representative Date_____

_____
Printed name of patient or legal representative and his or her relationship to patient Date _____

_____ Date _____
Witness Signature