

# Haven of Rest Counseling, PLLC

## Release of Information

103 W South Railroad St | Four Oaks, NC | 27524  
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[www.havenofrestcounseling.org](http://www.havenofrestcounseling.org)

Client Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address (street, city, state, zip) \_\_\_\_\_

I hereby authorize: Haven of Rest Counseling, PLLC and my therapist \_\_\_\_\_

And

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Relationship to client \_\_\_\_\_

**TO DISCLOSE TO AND COMMUNICATE TO ONE ANOTHER information contained in my patient records, to include anything checked below.**

### SPECIFIC INFORMATION TO BE DISCLOSED

<input type="checkbox"/> ASSESSMENT/DIAGNOSIS <input type="checkbox"/> COMMUNICATION EXCHANGE <input type="checkbox"/> PSYCHOSOCIAL/COUNSELING <input type="checkbox"/> TREATMENT PLAN/CONTRACT <input type="checkbox"/> LAB RESULTS <input type="checkbox"/> ADMISSION/DISCHARGE DATA SET <input type="checkbox"/> SCHOOL/WORK RECORDS <input type="checkbox"/> SCHOOL/WORK SOCIAL INVOLVEMENT	<input type="checkbox"/> PROGRESS REPORTS <input type="checkbox"/> RECOVERY PLAN <input type="checkbox"/> DISCHARGE SUMMARY <input type="checkbox"/> DR. DISCHARGE SUMMARY <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> REAUTHORIZATION FORMS <input type="checkbox"/> OTHER PERTINENT INFORMATION (Specify) _____ _____ _____ _____ _____ Dates of Service _____
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### PURPOSE AND NEED FOR SUCH DISCLOSURE

<input type="checkbox"/> CONTINUATION OF CARE <input type="checkbox"/> SCHOOL/WORK <input type="checkbox"/> REFERRAL FOLLOW-UP <input type="checkbox"/> FAMILY NOTIFICATION	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> RETURN TO SCHOOL/WORK <input type="checkbox"/> OTHER (Specify) _____ _____
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I understand that my medical record may contain reports, test results and notes that only a care provider can interpret. I understand and have been advised that I should contact my care provider regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record. I will not hold Haven of Rest Counseling, PLLC, or counselors liable for any misinterpretation of the information in my medical record as a result of not having consulted my care provider for the correct interpretation. I understand that generally my treatment may not be conditioned on whether or not I sign an authorization form, but that in certain limited circumstances I may be denied treatment if I do not sign an authorization form. This authorization is subject to a written revocation at any time except in those circumstances in which the counseling center has taken certain actions in reliance on such authorization. However, this authorization shall be valid no longer than is reasonably necessary to accomplish the purpose of the actions for which it was given. This authorization will automatically expire 12 months from the end of involvement in our programs or as specified in the revocation below.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Date \_\_\_\_\_ Witness \_\_\_\_\_

Relationship to Student \_\_\_\_\_ ☐ If student is a minor or incapable of signing, a copy of the appropriate legal documentation is attached if applicable. If I have joint custody, I have discussed this matter with the other legal guardian(s).

☐ **DRIVERS LICENSE/IDENTIFICATION VERIFIED**

REVOCATION (optional) – This authorization is revoked for the following specified dates, events, or conditions.

Date: \_\_\_\_\_ Event: \_\_\_\_\_ Condition: \_\_\_\_\_