SCA Information Release Form Instructions

Legal and ethical guidelines require SCA to obtain your signature on a Release of Information or Authorization form before disclosing information about you or your therapy to a third party (with some specific exceptions).

When you fill out the release form, you will need to check one of two boxes to indicate the purpose for the release. Please make sure your therapist tells you which of the two boxes to check.

By crossing out listed items or writing item(s) in, you can specify what kind(s) of information you wish to include or exclude from this release. The release will expire on year from the date of your signature unless you specify otherwise.

Please make sure someone observes your signature who can vouch for your identity, and have that person sign on the line labeled "Witness."

Thank you for your cooperation.

Southwest Counseling Associates
141 W. Davies Ave N
Littleton, CO 80120
Phone: 303.730.1717 • Fax: 303.730.1531

RELEASE OF INFORMATION OR AUTHORIZATION

I, _____ _____ / _____ / _____
Client's First Name | Middle Initial | Last Name | Client's Date of Birth

Authorize _____ to obtain information from, and share information with:

_____
Name of Doctor/Hospital/Person/Agency | Address | City, State, Zip | Phone#

Check only one box to indicate the purpose for which information is to be authorized/released:

☐ Treatment, Operations, or Payment (If checked, this form becomes a **Release** and services can be refused if client refuses to sign)
Specify: _____

☐ Other [e.g., Law (attorneys, probation), Education (schools) or Social Services] (If checked, this form becomes an **Authorization** and under HIPAA rules, services may not be conditioned or refused if client refuses to sign)
Specify: _____

- I understand that, unless lined-through, information to be released/authorized may include information regarding the following:
  - Assessment/Diagnosis/Family History
  - Treatment Summary and Recommendations
  - Psychological Testing/Consultation
  - Medical Information/Medications Prescribed
  - Psychiatric Conditions/Treatment
  - Other: _____
- I understand that if this is a Release for "Treatment, Operations, and Payment" purposes, SCA may withhold treatment, payment, enrollment, or eligibility for benefits if I refuse to sign.
- I understand that if this is an Authorization for "Other" purposes, SCA may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign or not.
- If the information to be released/authorized pertains to the diagnosis and treatment of alcoholism and/or drug abuse, I understand that the confidentiality of the information is protected by Federal Law 42.C.F.R. Part 2.
- I understand that there is potential for information disclosed, as a result of this release/authorization, to be re-disclosed by the recipient and therefore no longer protected by the HIPAA Privacy Regulation.
- I understand that I may revoke this release/authorization at any time by giving written notice to SCA, except to the extent that action has already been taken to comply with it. Without such revocation, this release/authorization will expire on _____ / _____ / _____, or if left blank, one year from the date of my signature, or as of the action or event of _____.
  Date
- I understand that I have a right to refuse to sign this form subject to the conditions noted above. **I am entitled to a copy of the signed form.**

_____ _____
Signature of Client/Parent/Legal Representative | Relationship to Client

_____ _____
Date | Witness

NOTICE TO WHOM THIS INFORMATION IS GIVEN: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Law prohibits you from making further disclosure of this information without the specific written consent of the person to whom it pertains.

A copy/facsimile of this Release/Authorization is as valid as the original.
SCA 06/14