RELEASE OF INFORMATION

I , _____
(Name of Client [print/type])

_____
(Street Address)

_____
(City State Zip Code)

Birthdate _____/_____/_____ **AGE**: _____
Mo. Day Year

authorize, _____
(Name and Title) phone / Fax

_____
(Organization)

_____
(Street Address)

_____
(City State Zip Code)

and *Duddleson Counseling LLC / Amanda J. Duddleson LCSW*, to release ____ **Verbally** and/or ____ **In writing** and/or ____**electronic/fax** the following information from the client's record to each other:

☐ **Check this box to allow sharing of any or all information,** *From dates _____through_____
or check individual boxes below to allow sharing of specific information:

	From Duddleson Counseling LLC /Amanda Duddleson, LCSW				**From above named person/ organization**		
	Alcohol/ Drug use information* _____initial		Medication		Alcohol/ Drug use information		Medication
	Attendance		Progress Record		Attendance		Progress Record
	Diagnosis		Treatment Plan		Diagnosis		Treatment Plan
	Discharge Summary		other _____		Discharge Summary		other _____
	Initial Assessment		other _____		Initial Assessment		other _____

(* for substance abuse , patient must sign, including minors age 14-17.)

PURPOSE OF DISCLOSURE(S):
__Comply with Order of the Court
__ Response to Referral Source
__ To Assist with Payment
__ Treatment of Client
__ Other _____

This authorization is subject to written revocation at any time. When a client/legal guardian revokes consent, *Duddleson Counseling LLC* and therapist, is not liable for items sent in the interim between authorization and revocation. Unless another date is specified, t**his voluntary release expires sixty (60) days after termination of treatment.**

✦Expiration date specified by patient/ legal guardian: ____/____/____.

SIGNATURES: (Please sign below to release information specified above)

***Client:**_____ **DATE**_____

Guardian:_____ **DATE**_____

Witness:_____ **DATE**_____

Notice to Recipient of Information sent by Amanda J.Duddleson LCSW: This information has been disclosed to you from records protected by the Federal confidentiality rules (42CFR Part2). Federal rues prohibit you from making any further disclosure of this information unless further is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CFR Part 2. A general authorization for the release of information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

SEND INFORMATION TO: AMANDA J. DUDDLESON, LCSW
222 S Frances St. South Bend, IN 46617-3004
phone : 574.635.5826
fax: 574. 314.6506