Dover Counseling Services, Inc
1311 Rucker Blvd.
Enterprise, AL, 36330

AUTHORIZATION FOR RELEASE AND DISCLOSURE, AND/OR REQUEST FOR MEDICAL INFORMATION AND RECORDS

I, _____(patient), _____ (date of birth) authorize Dover Counseling Services, Inc. to: (check one or both below)

_____ Release information from my medical records to the individual or organization listed below

_____ Request information from the individual or organization listed below

Name: _____

Address: _____

For the following purpose, use or need: _____

The following information from my psychiatric/medical records may be disclosed, covering the dates from _____ to _____.

___ Treatment Summary ___ Psychiatric Evaluation ___ Physical Exam

___ Psychological Testing ___ Laboratory Studies ___ Initial Assessment

Exchange of all written and verbal health information pertinent to the coordination of my care and treatment

_____ Other_____

Exclude the following information: _____

I acknowledge such information cannot be disclosed without my written informed consent unless otherwise provided by law. I further understand that such information to be disclosed may include treatment of Psychiatric, Substance Abuse, and HIV/AIDS related illnesses. I agree that the information may be faxed for expediency. I have the right to revoke this authorization at any time. Any revocation will be done in writing to the attention of Dover Counseling and any information previously authorized and released will not be subject to revocation. I acknowledge and authorize that the information indicated on this form will be sent to the individual listed above. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects the privacy of health information. Persons or organizations receiving this health information may not be bound by the provisions of the law. The released information may not be copied, shared or re-released, except as consistent with the authorized purpose stated above. I understand that I am not required to sign this authorization, and that Dover Counseling will not refuse me treatment if I refuse to sign. I have the right to inspect and obtain a copy of the information disclosed. A true and exact photocopy/faxed copy of this authorization shall have the same effect as the original.

If no expressed revocation is issued, this authorization will expire one year from the date indicated after my signature or upon the following date, event or condition: _____

I have also had the opportunity to have this form explained to me and have my questions answered.

_____ _____ _____ _____

Patient/Parent/Guardian Date Witness Signature Date