CONFIDENTIAL
ROI

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

CLIENT		BIRTH DATE	
GUARDIAN		TELEPHONE	
ADDRESS			
CITY/STATE/ZIP			

I authorize: Arukah Christian Counseling, 1639 West Main St. Albert Lea, MN 56007

☐ To release information to (and/or)

☐ Obtain information from:

NAME/TITLE	
ORGANIZATION	
ADDRESS	
CITY/STATE/ZIP	

This authorization includes:

☐ Session Attendance Record

☐ Clinical Assessment / Diagnosis

☐ Status of Treatment / Prognosis

☐ Treatment Plan / Goals

☐ Other: ____

☐ Any records, reports, test results, opinions, assessments and information related to medical, emotional, educational, psychological condition, progress, and treatment

I have read and reviewed Arukah Christian Counseling, Notice of Privacy Rights.
I understand that I may revoke this authorization at any time by providing written notice to Arukah Christian Counseling. I understand that this revocation will not affect a disclosure already under this authorization.
I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient, and is no longer protected by Arukah Christian Counseling's confidentiality rules.
I waive any right of privacy that I may have in connection with the disclosures hereby authorized.

This authorization takes effect the date signed below and expires:

☐ After requested information is given/received, or

☐ Continues for a period of one year from the date of signature below

CLIENT SIGNATURE		DATE	
PARENT/GUARDIAN SIGNATURE		DATE	

I, (client name) ___________________, revoke this authorization for the exchange of confidential information.

CLIENT SIGNATURE		DATE	
PARENT/GUARDIAN SIGNATURE		DATE	