

Main Street Counseling, LLC
1284 Jungerman Road
Suite B
St. Peters, MO 63376
636-498-0700

Continuity And Coordination Of Care Authorization Form For Release Of Health Information

Name of Client: _____
Last First Middle Maiden or Other Name

Date of Birth: _____ Phone Number: _____

I hereby authorize Main Street Counseling, LLC to release my medical/health information to:

Name: _____

Address: _____
Street City State Zip

Phone Number: _____ Fax Number: _____

Medical/Health Information to be Released

I authorize the release of the following specified information:

- Entire Medical/Health Record
- Progress Reports
- Substance Abuse Information (including Alcohol/Drug Abuse)
- HIV/AIDS related Information

Date of Authorization

This authorization is made for the following purpose(s):

- At my request
- Specify Purpose: _____
- Referral to Other Professionals
- Consultation with Other Professionals

CONDITIONS OF AUTHORIZATION

1. This authorization is valid for 6 months from today's date: _____
2. I may revoke this Authorization at any time by notifying Main Street Counseling in writing. It will be effective on the notification date except to the extent that Main Street Counseling has already acted upon such authorization.
3. Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.
4. By authorizing this Release of Information, my healthcare and payment for my healthcare will not be affected if I do not sign this Authorization form.
5. I have been offered a copy of this signed Authorization form.

Signature Of Client (Or Parent/Legal Guardian Or Other Authorized Person)

Date