WHERE FAMILIES COME FIRST
Desert View
FAMILY COUNSELING SERVICES

Authorization for Release of Protected Health Information

Date: _____ Name of Client: _____ DOB: _____

I hereby authorize **Desert View Family Counseling**, 6100 E. Main St., Farmington, NM 87402 to

☐ **disclose to the following:** ☐ **obtain from the following:**

_____
Name of Agency Name of Contact

_____
Address, City, State, Zip Phone Fax

IT QU

☐ Mental Health Assessment
☐ Treatment Plan
☐ Treatment Recommendations
☐ Progress Notes (Consult with Therapist first)
☐ Lab Results
☐ Other: _____
☐ Substance Abuse Assessment
☐ Diagnosis
☐ Attendance & Progress (Tracking)
☐ Discharge Summary

The information to be released is for the following purposes:
☐ Evaluation ☐ Treatment ☐ Compliance ☐ Discharge Planning
☐ Other: _____

I understand that this consent authorizes the release of information on an ongoing basis. I understand that I may revoke this consent at any time. I understand that treatment does not depend on whether or not I sign this consent. This consent is valid for a period of _____. (If no period is specified, the consent is valid for one year.) I understand I have the right to examine and copy the information disclosed, provided the clinician believes it is in the patient's best interest.

_____ _____
Client Signature Date

_____ _____
Parent / Guardian Signature (required if client is 14 years old or younger) Date

_____ _____
Witness Date

ONLY SIGN BELOW IF YOU WANT TO REVOKE THIS CONSENT TO RELEASE INFORMATION!

I understand that disclosures made in good faith may have already occurred in reliance upon my previously issued authorization and that this revocation cannot apply retroactively to such disclosures.

_____ _____
Client Signature Date

Prohibition of Redisclosure: Federal Law (42CFR, Part 2) and State regulations (32A-6-15 NMSA 1978 and 24-2B-7, NMSA 1978) prohibit further disclosure of this information to any person or agency without securing another proper written authorization for that purpose.