Counseling and Psychological Services of the Upstate
402-4 Pendleton Rd.
Clemson, SC 29631
864-633-0210

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

This form, when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate. You may also permit me to obtain information from another person or agency.

I, _____ _____
(printed name) (date of birth)

Authorize Christopher E. Ruth, Ph.D., to:

____ Provide information to **Person or Agency:** _____

____ Obtain information from **Address:** _____

_____

Phone: _____ **Fax:** _____

The information being released/obtained includes:

____ Receipt of services from Christopher E. Ruth, Ph.D.____ Diagnosis ____ Intake/Termination/Treatment Summary

____ Treatment History/Progress ____ All records ____ Other: _____

_____ HIV/AIDS related records ____ Drug/alcohol diagnosis, treatment or referral information

The purpose of the information being released/obtained is for:

____ Documenting Receipt of Services from Christopher E. Ruth, Ph.D. ____ Continuity/Transfer of Services

____ Safety Planning and/or Risk Management ____ Additional Support with Treatment/Progress

____ Intake/Termination/Treatment ___ Other: _____

This authorization shall remain in effect for one year of date signed or until: _____

You understand that you have the right to revoke this authorization, in writing, at any time by sending written notification to the office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
I am aware of my right to confidential communications under psychologist-patient privilege.
I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Printed Name of Client Client Date of Birth

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian (if applicable) Date