Genuine Therapy Center, LLC
Real Conversations. . . Real People

Permission to Obtain and Disclose Privileged and Confidential Information and Records "Probation"

Revised 07.2.2015

Therapeace Counseling, llc

This document requests your written permission to grant to Therapeace Counseling, LLC/Genuine Therapy Center, LLC permission to discuss and/or release your federally protected and confidential personal physical/mental health and legal information. This information is both private and confidential. The oral communication and written material TP/GTC will receive and transmit is important to assess accurately, to treat, and to coordinate your physical and mental health care.

I authorize Therapeace Counseling, LLC/Genuine Therapy Center, LLC to receive and to transmit (both orally and in writing) oral, written, and/or electronic copies of my personal and confidential physical/mental health and legal information. I understand that this information is protected under federal and state privacy regulations and that once Therapeace Counseling, LLC/Genuine Therapy Center, LLC obtains my information it is prohibited, by federal and state law, from further disclosing it without my written consent—unless otherwise provided for in federal and state regulations.

I understand that I may revoke my authorization at any time after granting it, but my revocation cannot withdraw any information that has already been released to or by TP/GTC or according to my written directions to re-disclose it. My authorization to obtain and/or re-release my confidential physical/mental health and legal information will expire in one year from the date below.

This information may be used for:

No	Yes		No	Yes	
□	**x**	Legal Update	□	**x**	Verification of Client Info
x	□	Insurance Benefits ID/ Claim Review	**x**	□	Application for Insurance

Information and records that may be accessed and obtained:

No	Yes		No	Yes	
□	**x**	Collection of Collateral Data	**x**	□	Insurance Benefits
x	□	Accounts Receivable/ Billing/ Collections	□	**x**	Emergency Contact
□	**x**	Social and Legal History	□	**x**	Chemical Use History
x	□	Physical and Mental Health History	□	**x**	Alcohol/Drug Tests
x	□	Medication Validation/Checks	□	**x**	Supervision
□	**x**	Presence in Treatment	□	**x**	Change in Status
□	**x**	Progress Reports	□	**x**	Transfer/Discharge Report
□	**x**	Aftercare Plans	□	□	Other (specify) ________

*****NOTE**: By MN Statute, a Discharge Summary Must Contain the Date of Last Chemical Use.*

Therapeace Counseling, LLC/Genuine Therapy Center, LLC may have oral and written two-way communication with:

Name: ____ Relationship: ________________________

Address: ____

City, State, Zip: ____________________________________ Phone: ______________________________

Fax: ______________________________

Client Name: ____ Client's Date of Birth: ______________

DISCLOSURE OF THIS MATERIAL IS PROHIBITED BY FEDERAL LAW: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse/dependency patient/client.

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Client Signature: ___________________________________ Date: ___________________________

Team Member Signature: ____________________________ Date: ___________________________

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