# Empowerment Counseling Center of Rhode Island

Authorization for Release of Information

Client's Name: _____Date of Birth:_____
Authorizes Empowerment Counseling Center of RI to OBTAIN from and RELEASE to:
Name: _____
Address: _____Phone #:_____
The information to be released pertaining to my identity, prognosis, diagnosis or treatment shall include:
❍ Progress Notes ❍Treatment summary ❍ Psychiatric evaluation
❍ Discharge summary ❍ psychosocial history
❍ Other (specify) _____

This information is needed for the following purpose(s):
❍ Evaluation & Treatment ❍
Other_____

Permission for exchange of information will continue for the duration of the client's treatment or date otherwise specified. Permission may be withdrawn at any time through a signed written statement.

I understand that records of Empowerment Counseling Center of RI are protected under Rhode Island General Law and cannot be disclosed without my written consent except as otherwise specifically provided by law. I also understand that if my records involve alcohol or drug abuse they are protected under the Federal Regulation 42 CFR, confidentiality of Alcohol and Drug Abuse.

I release Empowerment Center of Rhode Island and its employees from any liability arising from the release of this information to such persons/agencies, provided that said release of information is done substantially in accordance with applicable law.

I have read and understand the above statements and do herein voluntarily consent to disclosure of the above information to those person/agencies named above.

I also consent to the release of my records or any part thereof, through the use of a facsimile machine, with the understanding Empowerment Counseling Center of Rhode Island cannot exclusively guarantee the confidential transmittal of records via Fax delivery. ❍ Yes ❍No

Signature of Client or legal guardian:
_____Date:_____

Witness from Empowerment Counseling Center of RI:
_____Date:_____