141 Providence Rd., Suite 100
Chapel Hill, NC 27514
www.cohesivepathways.com
COHESIVE PATHWAYS PC

Authorization to Release Information

I, _____, do hereby consent to and authorize as indicated:
Print Name (*Client/Parent/Guardian*)

☐ Obtain from: by ☐ Photocopy ☐ Fax
☐ Release to: by ☐ Photocopy ☐ Fax
☐ Exchange Oral Information with:

Michael Jokich, LCSW
Cohesive Pathways, PC
141 Providence Rd., Suite 100, Chapel Hill, NC 27514
Phone: (919) 636-5982
Fax: (919) 640-8050

Agency/Facility: Dates of Service:

Address City State Zip code

Contact: Phone: Fax:

Regarding Client:

Name:

Date of Birth: SSN:

Information to be Disclosed

☐ My mental health record in its entirety; and/or ☐ My substance abuse record in its entirety; or
☐ Only the following information *(Check each item to be released):*

- ☐ Presence in treatment (including dates of service)
- ☐ Intake evaluation, including substance use
- ☐ Treatment Plan
- ☐ Diagnosis, brief description of progress and prognosis
- ☐ Psychological tests or projective assessments
- ☐ Progress Notes, including therapy notes
- ☐ Medications
- ☐ Legal Information (including police reports)
- ☐ Evaluations
- ☐ Substance abuse information
- ☐ Other:

Purpose for Disclosure

☐ To facilitate diagnostic assessment and treatment planning
☐ To permit continuity of care
☐ To permit coordination & collaboration of care ☐ Other: _____

At any time, I may revoke this consent orally or in writing. I understand that the revocation will not be effective retroactively for information exchanges that have already occurred. Unless otherwise noted, this consent expires one (1) year from the date of my signature below.

_____ _____
Signature of client Date

_____ _____
Signature of parent, guardian, conservator or other authorized representative (when required) Date

_____ _____
Witness Date

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits 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 CFE 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 member.