Be You Counseling Services, LLC
640 George Washington Highway, Building B, Suite 103 #19
Lincoln, RI 02865
401-580-8452

AUTHORIZATION FOR USE AND DISCLOSURE OF CONFIDENTIAL INFORMATION

Client Name: _____

I hereby authorize: **Naydeen Kafalas, LMHC**
640 George Washington Highway, Suite 103,#19
Lincoln, RI 02865

To: ☐ **OBTAIN FROM:** ☐ **RELEASE TO:**

Person or Organization to Release or receive information:

_____

_____

_____

Information to be disclosed: _____

Method of Release:

☐ Verbal Communication ☐ Written Communication

Purposes of the Request:

☐ Client Care ☐ Client Request ☐ Case Coordination/Advocacy

☐ Other (specify): _____

I understand that the information in the record my relate to treatment for alcohol and drug abuse and/or the results of diagnostic tests use to determine if the individual is infected by the Human Immunodeficiency Virus (HIV). Unless I have indicated otherwise above, I specifically authorize the release of this information.

I understand that I have the right to revoke this authorization at any time. I understand that I can refuse to sign this authorization. I understand that this authorization will have a duration of no longer than one (1) year form the date upon this form was signed. I understand that to revoke this authorization, I must do so in writing and send written revocation to Naydeen Kafalas, LMHC. I understand that the revocation will not be effective until it is received, and it will not apply to information that has already been released in response to this authorization. I further understand that once my information is disclosed to the above person or organization Naydeen Kafalas, LMHC is not liable for the recipient's actions/ and use with regard to my information. Once the information is sent, it may no longer be protected by the federal rule on privacy records. I also understand that a revocation will not apply to my insurance company when the law provides the insurer with the right to contest a claim under my policy.

I have read carefully and understand the above statements and voluntarily consent to the disclosure of the above information to the person or organization identified above.

_____ _____
Signature of Client or Authorized Representative **Date**

_____ _____
Printed Name of Authorized Representative **Date**

If Naydeen Kafalas, LMHC is seeking this authorization for her own use or disclosure of confidential information, a copy of this authorization will be given to the client or his/her personal representative.