BENSON PSYCHOLOGICAL SERVICES, PC
1308 23rd Street South
Fargo, ND 58103
Phone (701) 297-7540
Fax (701) 297-6439

AUTHORIZATION TO DISCLOSE INFORMATION

INSTRUCTIONS: Provide information as it existed when the service was provided.

Name of Client: (Last, First, Middle Initial)	Phone Number:	Date of Birth:
Street Address:	City:	State/Zip Code:

CLIENT RELEASE AND SIGNATURE:

1. I Hereby Authorize			
Name of Person/Agency: Benson Psychological Services, PC			
Street Address: 1308 23rd Street South	City: Fargo	State: ND	Zip Code: 58103
2. To Release Information To, Receive Information From, Or Mutually Exchange Information With			
Name of Person/Agency to Receive Information:			
Street Address:	City:	State:	Zip Code:

Communication is Allowable By:

___Phone Call
___Email
___Written Correspondence
___Text Message
___Face to Face
___Other

3. The Following Information is Requested:

___ Communication Exchange in Verbal and Written Form
___ Medical/Physical Reports
___ Notice of Initial Contact
___ Addiction Evaluation/Recommendation
___ Results of Any Drug Screening
___ Discharge or Treatment Summary
___ Laboratory Reports
___ Educational Evaluation/Report
___ Psychological Evaluation/Recommendations
___ Legal History/Reports
___ Psychiatric Evaluation/Recommendations
___ Reason for Referral
___ Treatment Program Reports
___ Other (Specify)

4. The Information Identified Above Will Be Used For:

___Coordination of Services
___Legal Proceedings
___Evaluation and Program Determinations
___Obtaining Collateral Information
___ Treatment
___Other (Specify)

CLIENT CONSENT:

This authorization is voluntary and remains in effect until the above date or event, unless specifically revoked by written notice to the agency or person. Refer to the Notice of Privacy Practices for further description of revocation rights. Any information disclosed prior to written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this authorization is as effective as the original. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium, including oral, written, or electronic transmission.

Signature of Client:	**Date:**	**Expires:**
Signature of Parent/Guardian or Custodian (if needed and relationship):	**Date:**	**Expires:**
Signature of Witness (if needed):	**Date:**	**Expires:**

___ Check if Applicable – Notice To Whomever Disclosure Is Made Concerning Addiction Records
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 authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to investigate criminally or prosecute any alcohol or drug abuse patient.