The Behavioral Change Clinic, PLLC
with Dominic C. Moceri, PhD
200 East Big Beaver Road, Troy, MI 48083
Phone: 248.564.1183 | Fax: 248.458.4578
www.BehavioralChangeClinic.com

RELEASE FORM

By completing and signing this form, I am granting permission for **The Behavioral Change Clinic, PLLC** (The Clinic) and **Dominic C. Moceri, PhD** (Therapist) to communicate with the specified individual person(s) and/or organization(s) about the Client regarding the information specified below.

Section 1 – Client Information

A. Name of Client: _____
B. Date of Birth of Client: _____
C. Name of Person Completing This Form: _____
D. Relationship to Person Completing This Form to the Client: _____
(self; parent; legal guardian)

Section 2 – To Whom is the Information being Shared: *If you want to authorize only a specific individual(s) at an organization, write their name(s). If you want to authorize multiple people, you may "XYZ Staff," "XYZ Treatment Team," or something similar.*

E. Name of Person(s): _____
F. Name of Organization (if any): _____
G. Contact Information:
1. **Address (Street, City, Zip):** _____
2. **Phone 1:** _____ **(Mobile/Home/Work)**
3. **Phone 2:** _____ **(Mobile/Home/Work)**
4. **Email*:** _____
5. **Fax:** _____

** Email is not considered a secure method of communication. If you use a school/employee email, the school/employer may have a legal right to read the email. Emails sent from The Clinic will be encrypted in a HIPAA secure manner. Only include an email if you are consenting to communication using that medium. Please, see "COMMUNICATION POLICY FORM" for additional important privacy information.*

Section 3 – Type of Information to Be Shared: *Please check or initial each type of disclosure that you wish to authorize.*

H. Checkmarks or Initials:
1. _____**Psychotherapy Treatment Summary & Recommendations of Therapist**
2. _____**Medical and Medication History & Treatment**
3. _____**School & Academic Functioning**
4. _____**Social History**
5. _____**Alcohol & Substance Abuse History (if any)**
6. _____**Billing & Scheduling** (if another adult is making payments directly)

I. Additional Authorized Topics: _____
_____
J. Exclusions and Limitations: _____
_____

Section 4 – Duration of Release: This authorization shall expire in one calendar year from the date of signing, or as required by the law or court order. If you would the release to terminate sooner, please write the expiration date under "*Exclusions and Limitations*" above.

Section 5 – Client Rights: I understand that I am permitted to revoke the communication authorization of this release form at any time by submitting in writing to The Clinic at the address listed at the top of this document. As soon as that information is received, The Clinic will cease releasing any additional information to the person(s) and/or organization. I understand that neither the signing of this form nor the revocation of this authorization will determine my eligibility to receive treatment at The Clinic from my Therapist, unless signed and documented in another form and/or letter. Additional rights and/or privileges may be provided by The Clinic's "Privacy Notification Form," federal law (including HIPAA), state law, and other authorized sources.

Section 6 – Notification: Notification **to the designated person(s) and/or organization specified above** in "To Whom is the Information being Shared":

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 information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

Section 7 – Signature: I have read and understand the nature of this release. I release the my Therapist, The Clinic, and any other associates of The Clinic from any liability that may arise from this action whether or not foreseen at present. I understand that certain medical records (including any alcohol and drug abuse information) may be protected by Federal Regulations (e.g., Health Insurance Portability and Accountability Act of 1996 [45 C.F.R.]; Parts 160 and 164 the Drug Abuse Office and Treatment Act of 1972 [21 U.S.C. 1175]; Comprehensive Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 [42 U.S. C. 4582]).

I have read the Release Form and agree to its terms. I have been given an opportunity to ask questions and express any concerns that I may have.

Client, Parent, or Guardian Signature	**Date**	**Clinician Signature**	**Date**