Be My Neighbor Counseling

Authorization to Exchange Information

Release of Information / Care Coordination

Phone: 406-414-7011 | Email: bemyneighborcounseling@gmail.com

This form authorizes Be My Neighbor Counseling to communicate with the person(s) or organization(s) identified below for the specific purposes and information categories selected. Complete only the sections you wish to authorize.

Client Information

Client Name: _____

Date of Birth: _____

Person or Organization Authorized to Receive Information

Name/Organization: _____

Role/Relationship: _____

Phone/Email: _____

Purpose of Communication

☐ Care coordination

☐ Treatment planning

☐ Medication coordination

☐ Case management / resource coordination

☐ Continuity of care

☐ Other: _____

Information Authorized for Disclosure

☐ General treatment participation and scheduling information

☐ Treatment goals and progress

☐ Mental health assessment/treatment information

☐ Medication-related information

☐ Substance-use treatment information, only when specifically authorized and legally permitted

☐ Relevant medical information

☐ Other specific information: _____

I understand that I should authorize only the information necessary for the stated purpose. Additional or specially protected information may require separate authorization under applicable law.

Expiration and Revocation

Unless otherwise required by applicable law, this authorization expires on: _____. I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken based on this authorization. Revocation does not affect disclosures already made in reliance on the authorization.

Voluntary Authorization

I understand that signing this authorization is generally voluntary. I understand the information that may be disclosed, the person or organization receiving it, and the purpose of the disclosure. I may ask questions before signing.

Client Name:	_____
Client Signature:	_____
Date:	_____
If signed by personal representative, relationship:	_____

Supervision Information

I am currently a graduate student in a Mental Health Counseling program and provide services under clinical supervision. My supervisor's information is listed below.

Clinical Supervisor:	Onnie Michalsky
Professional License:	MA, EdS, LCPC, NCC
License Number:	LIC#38831
Supervising Organization/Practice:	DBA Mom’s Without Capes onnie@momswithoutcapes.com