# Breakthrough Therapeutic Concepts, LLC

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## Consent for Release of Information (ROI) and Use of Confidential Information

Client First Name _____ M.I _____ Client Last Name _____ Date of Birth _____

**I authorize BTConcepts Staff to:**

☐ receive information ☐ send information ☐ exchange information

**The following information:**

| | | | | |
|---|---|---|---|---|
| | Intake Information | | | Social history |
| | Progress Notes | | | Educational records |
| | Treatment Plan | | | Work records |
| | Medical History | | | Service Coordination |
| | Developmental History | | | Discharge plan |

Other: _____

**With (Information Regarding Authorized Party):**

Printed Name (First, Last) _____ Relationship to Client _____

Contact Information (Phone Number[s]) _____

**The above information will be used for the following purposes:**

| | | | |
|---|---|---|---|
| | Planning appropriate treatment or program | | Case review |
| | Continuing appropriate treatment or program | | Updating files |
| | Determining eligibility for benefits or program | | Other: _____ |

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I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

I understand that I have the right to request that my provider restrict how my individually identifiable mental health information is used and/or disclosed to carry out treatment, payment, or health operations. I understand that my therapist does not have to agree to such restrictions, but that once such restrictions are agreed to, my therapist must adhere to such restrictions.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

| | | |
|---|---|---|
| _____ | _____ | _____ |
| Signature & Printed Name | Relationship to Client | Date |
| _____ | _____ | _____ |
| Signature & Printed Name | Relationship to Client | Date |
| _____ | _____ | |
| Evaluator Signature & Printed Name | Date | |