

**General Information - Adult**

Thank you for choosing Charis Institute. We sincerely hope this will be a place of healing for you. Please take the time to fill out all of these forms and read all of the information regarding your treatment, the payment, and your insurance policy.

**When 24-hour notice is not given there will be a charge of \$35 for missed appointments.**

Where did you hear about our services or who referred you? \_\_\_\_\_

**Client Information**

_____	_____/_____/_____	_____-_____-_____
Name	Date of Birth	Social Security Number
_____	(____)_____	(____)_____
Mailing Address	Home Phone	Cell Phone
_____	_____	_____
City	Zip Code	Occupation
_____	_____	(____)_____
Employer/School	Work Phone	_____

**For your comfort and assurance of confidentiality we ask that you please read over the following and sign:**

- I give permission for charis institute to call my cell or home and leave a message on the answering machine or with anyone who answers the phone.
- I give permission for charis to call my work number if I need to be reached.

\_\_\_\_\_  
**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Marital Status:**  Single  Married  Divorced  Separated **If you are married, please state how many years** \_\_\_\_\_

_____	_____-_____-_____	_____	_____/_____/_____	_____
Spouse's Name	Social Security Number	Age	Date of Birth	Employer

**If you have children please list (include ages)** \_\_\_\_\_

**Person Responsible For Account (If other than the client, by providing this information you are allowing us to release relevant information to this individual, regarding billing)**

_____	_____/_____/_____	_____-_____-_____
Name	Date of Birth	Social Security Number
_____	(____)_____	(____)_____
Mailing Address	Home Phone	Cell Phone

**Insurance Information**

_____	_____	_____
Insurance Company	Policy Number/Member ID	Group Number
_____	_____	_____/_____/_____
Insurance Company Address	Name of Cardholder	Cardholder DOB
_____	_____	_____
Mailing Address of Cardholder	City	State
_____	_____	_____
	_____	Zip

**Method of Payment** Please check the method of payment that you will be using.

Cash Charge Payment Plan Insurance/Co-Pay or Deductible

You should be aware that different insurance companies vary greatly in the types of coverage available. Some insurances require prior authorization for treatment. Prior to your appointment it is your responsibility to contact your insurance to see if authorization is required. We ask that you look upon your insurance realistically as a device which helps you pay for your care here at Charis Institute. Please understand that assisting you with your insurance claim is done willingly but that regardless of the insurance coverage, the obligation for the fee for the services rendered is yours. All fees will be due on the day of treatment even if you have insurance unless arrangements are made in advance with our office. Insurance companies typically limit their coverage to services that they consider medically necessary. In the event that you receive services and your insurance determines it did not meet their criteria, you understand that you are responsible for payment for these services. I hereby authorize treatment. I authorize Charis Institute to furnish insurance carriers with any medical information necessary to process this claim. I hereby assign to Charis Institute all payments for services rendered to my dependents or myself. I acknowledge that insurance claims pending beyond 60 days are my responsibility and I agree that I will not delay payment and that I will pay the balance if a claim is pending more than 60 days. I understand that if I make a payment and payment is received later by Charis from my insurance company, I will be reimbursed. If a check is returned to Charis Institute, I understand that I will be responsible of paying the fee that bank charges them. I have read and understand the Privacy Policy that is posted in the office.

\_\_\_\_\_  
**(Signature/Guarantor)** \_\_\_\_\_ **(Date)** \_\_\_\_/\_\_\_\_/\_\_\_\_\_

## Adverse Childhood Experience (ACE) Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

This Questionnaire will be asking you some questions about events that happened during your childhood; specifically the first 18 years of your life. The information you provide by answering these questions will allow us to better understand problems that may have occurred early in your life and allow us to explore how those problems may be impacting the challenges you are experiencing today. This can be very helpful in the success of your treatment.

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often:

Swear at you, insult you, put you down, or humiliate you?

Or

Act in a way that made you afraid that you might be physically hurt?

Yes  No

If Yes, enter 1 \_\_\_\_\_

2. Did a parent or other adult in the household often:

Push, grab, slap, or throw something at you?

Or

Ever hit you so hard that you had marks or were injured?

Yes  No

If Yes, enter 1 \_\_\_\_\_

3. Did an adult or person at least 5 years older than you ever:

Touch or fondle you or have you touch their body in a sexual way?

Or

Attempt or actually have oral, anal, or vaginal intercourse with you?

Yes  No

If Yes, enter 1 \_\_\_\_\_

4. Did you often feel that:

No one in your family loved you or thought you were important or special?

Or

## Adverse Childhood Experience (ACE) Questionnaire

Your family didn't look out for each other, feel close to each other, or support each other?

Yes  No

If Yes, enter 1 \_\_\_\_\_

5. Did you often feel that:

You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

**Or**

Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

Yes  No

If Yes, enter 1 \_\_\_\_\_

6. Were your parents ever separated or divorced?

Yes  No

If Yes, enter 1 \_\_\_\_\_

7. Were any of your parents or other adult caregivers:

Often pushed, grabbed, slapped, or had something thrown at them?

**Or**

Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?

**Or**

Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

Yes  No

If Yes, enter 1 \_\_\_\_\_

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

Yes  No

If Yes, enter 1 \_\_\_\_\_

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

Yes  No

If Yes, enter 1 \_\_\_\_\_

10. Did a household member go to prison?

Yes  No

If Yes, enter 1 \_\_\_\_\_

**ACE SCORE (Total "Yes" Answers): \_\_\_\_\_**

### Confidential Adult Biosocial History

Please take the time to complete this information as it will assist your therapist in understanding and treating you and your problems. Completing this information in advance allows you to spend less time on information gathering activities during your first session. If you need help in completing these forms, please let your therapist know. *Please Check All That Apply.*

- 1) What is your education?  Elementary  High School  College  Graduate School  Vocational Training
- 2) What is your estimated reading level?  Cannot Read  Elementary School  Middle School  High School or above
- 3) Please list current or past significant medical problems (also previous mental health diagnoses) \_\_\_\_\_
- 4) List all of your allergies \_\_\_\_\_
- 5) List all prescription drugs you are now taking (include name, amount, how often taken, and how long taken): \_\_\_\_\_
- 6) Check current non-prescription drug use (if you mark "other" please specify on line provided).  
**Alcohol:**  Beer  Wine  Whiskey  
**Sedatives:**  Nerve Pills  Tranquilizers  
**Hallucinations:**  LSD  PCP  Acid  
**Stimulants:**  Pep Pills  Diet Pills  Cocain  Speed  Soft Drinks  Coffee  Tea  
**Pain Killers:**  Darvon  Codeine  Demerole  
**Inhalants:**  Paint thinner  Glue  Other \_\_\_\_\_  
**Narcotics:**  Marijuana  Hash  Heroin  Other \_\_\_\_\_  
**Other:**  Over the Counter  Home Remedies  Street Drugs  Other \_\_\_\_\_
- List accidents or broken bones: \_\_\_\_\_  
*Did any accidents result in periods of unconsciousness?*  Yes  No
8. List hospitalizations and surgeries and give the dates: \_\_\_\_\_
9. Previous outpatient mental health treatment (List name of therapist, address, dates of treatment, and frequency of sessions) \_\_\_\_\_
10. Previous inpatient mental health treatment (List facility, address, and dates of treatment) \_\_\_\_\_
11. Give a brief sexual history, at what age became sexually active, description of current sexual behavior, along with any sexual problems/concerns \_\_\_\_\_
12. As a mother or a father, please check if you have had any of the following and on the line state how many of each:  
 Abortion(s)  Miscarriage(s)  A child die
13. List last physical examination and the name of the Doctor seen for the examination. \_\_\_\_ / \_\_\_\_ / \_\_\_\_ \_\_\_\_\_
14. What is your religious background? \_\_\_\_\_ Name of Home Church \_\_\_\_\_  
How important are religious/spiritual practices to you?  Very Important  Important  Neutral  Unimportant
15. Please check any of the following that you participate in or attend.  Support Group  12 Step Program  Church or Religious Group  Social Clubs/Organizations  Other \_\_\_\_\_
16. Please check the status of your parent's marriage:  Married/Living Together  Separated  Divorced  One Deceased  Both/All Deceased  
Mother's Age: \_\_\_\_\_ Father's Age \_\_\_\_\_  
How old were you at the time of your parent's (Separation, Divorce, Mother's Death, or Father's Death) \_\_\_\_\_  
If your parents are divorced, did either remarry, and when? Mother \_\_\_\_\_ Father \_\_\_\_\_
17. List ages of older brothers: \_\_\_\_\_ List ages of younger brothers: \_\_\_\_\_  
List ages of older sisters: \_\_\_\_\_ List ages of younger sisters: \_\_\_\_\_
18. Give any general comments on childhood Issues: \_\_\_\_\_
19. During most of your childhood, who did you live with?  Both Natural Parents  Single Parent  Parent and Step Parent  Relatives  Adoptive or Foster Family  Other \_\_\_\_\_
20. Check the problems that you had when you were growing up:  Alcohol or Drug Use  Trouble w/ Law  Few Friends  Emotional Problems  Physically Abused  Sexually Abused  Emotionally Abused  Moved Frequently  Neglected  Eating Disorder  Shyness  Serious Illness  Other \_\_\_\_\_  None
21. How did you see yourself while growing up?  Never Fitting In  Stayed in the Background  As "Ugly"  As an Outsider  As a "Failure"  As "Stupid"  Unpopular  Well Liked  As "Pretty"  Felt Accepted  As "Smart"  Took Part in Activities  Your needs were ignored  Your needs were not important  You felt you could count on those around you to tend to your needs  You could never please your parents  You had to fight for whatever you wanted  You ended up taking care of others **Other** \_\_\_\_\_ *Do you see yourself differently now?*  Yes  No
22. How did your family related to the rest of the world?  Enjoyed being with people, whether at home or in the community  Unknown  Had some contact with friends and family  Isolated and seldom were with people in an enjoyable way  Suspiciousness of others
23. Has any other family member ever had any of the following problems :  Alcohol/Drug  Physical Illness  Financial

**Confidential Adult Biosocial History**

- \_\_\_\_ Emotional/Psychiatric \_\_\_\_ Legal \_\_\_\_ Sexually Abusive \_\_\_\_ Physically, Emotionally Abusive \_\_\_\_ Attempted Suicide  
\_\_\_\_ Committed Suicide Other \_\_\_\_\_ Did they receive help for the problems? \_\_\_\_\_
24. Which of the following describes your father's health? \_\_\_\_ Excellent \_\_\_\_ Good \_\_\_\_ Fair \_\_\_\_ Poor \_\_\_\_ Deceased \_\_\_\_ Unknown  
Which of the following describes your mother's health? \_\_\_\_ Excellent \_\_\_\_ Good \_\_\_\_ Fair \_\_\_\_ Poor \_\_\_\_ Deceased \_\_\_\_ Unknown
25. How would you describe your relationship with your father now? \_\_\_\_ Very satisfied \_\_\_\_ Satisfied \_\_\_\_ Dissatisfied \_\_\_\_ Very Dissatisfied  
\_\_\_\_ No Relationship  
How would you describe your relationship with your mother now? \_\_\_\_ Very satisfied \_\_\_\_ Satisfied \_\_\_\_ Dissatisfied \_\_\_\_ Very dissatisfied  
\_\_\_\_ No Relationship  
How would you describe your relationship with your siblings now? \_\_\_\_ Very satisfied \_\_\_\_ Satisfied \_\_\_\_ Dissatisfied \_\_\_\_ Very dissatisfied  
\_\_\_\_ No Relationship
26. Did you ever serve in the military? \_\_\_\_ Yes \_\_\_\_ No **If yes, how long did you serve?** \_\_\_\_ What kind of discharge did you receive  
\_\_\_\_\_
27. What do you like to do in your free time? \_\_\_\_ Sports \_\_\_\_ TV/Radio \_\_\_\_ Gardening \_\_\_\_ Reading \_\_\_\_ Exercise \_\_\_\_ Crafts  
\_\_\_\_ Hunting/Fishing \_\_\_\_ Other \_\_\_\_\_
28. Which describes your family's understanding of your seeking services? \_\_\_\_\_ Your family does not know you are here.  
\_\_\_\_ Your family knows you are seeking services and are willing to participate. \_\_\_\_ Your family knows that you are seeking  
services but they do not want to participate.
29. How do you feel about coming in for services? \_\_\_\_ Positive \_\_\_\_ Uninterested \_\_\_\_ Scared./Nervous \_\_\_\_ Neutral
30. What are your current stressors? \_\_\_\_ Work \_\_\_\_ Family \_\_\_\_ Marital/Relationship \_\_\_\_ Housing \_\_\_\_ Parenting \_\_\_\_ Divorce/Break Up  
\_\_\_\_ Recent Mov \_\_\_\_ Financial \_\_\_\_ Legal \_\_\_\_ School/Educational \_\_\_\_ Health/Physical \_\_\_\_ Religious/Spiritual \_\_\_\_ Sexual abuse  
\_\_\_\_ Physical Abuse \_\_\_\_ Spousal Abuse \_\_\_\_ Serious Illness of Loved One \_\_\_\_ Death/Loss Other \_\_\_\_\_
31. Which of the following problems do you feel you need help with? \_\_\_\_ Depression \_\_\_\_ Anxiety \_\_\_\_ Parenting \_\_\_\_ Intense Anger \_\_\_\_  
Compulsive Behaviors \_\_\_\_ Eating Disorder/Body Image \_\_\_\_ Loss, Death \_\_\_\_ Divorce/Separation \_\_\_\_ Sexual Problems  
\_\_\_\_ Religious/Spiritual Concerns \_\_\_\_ Abusing Others \_\_\_\_ Drug/Alcohol \_\_\_\_ Issues Related to Past Abuse \_\_\_\_ Problems with  
Sleep or Appetite \_\_\_\_ Unexplained Frequent Changes in Moo \_\_\_\_ Recurring Thoughts of Death \_\_\_\_ Hearing Voices or Seeing  
Strange Visions \_\_\_\_ Very Fast Thoughts or Feeling \_\_\_\_ Difficulty with Memory, Concentration, or Decision Making \_\_\_\_  
Other \_\_\_\_\_
32. Have you ever seriously injured another person? \_\_\_\_ Yes \_\_\_\_ No
33. Do you ever think of harming someone else? \_\_\_\_ Yes \_\_\_\_ No
34. Have you ever: \_\_\_\_ Thought of Suicide \_\_\_\_ Attempted Suicide \_\_\_\_ Hurt/Cut Yourself **If so, how many times**  
\_\_\_\_\_
35. Marital History: First marriage date \_\_\_\_\_, **If divorced:** Date \_\_\_\_\_, brief description of problem: \_\_\_\_\_  
Second marriage date \_\_\_\_\_, **If divorced:** Date \_\_\_\_\_, brief description of problems \_\_\_\_\_
36. Who do you live with? \_\_\_\_ Spouse \_\_\_\_ Significant Other \_\_\_\_ Children \_\_\_\_ Grandchildren \_\_\_\_ Parent \_\_\_\_ Grown Children \_\_\_\_  
Grandparents \_\_\_\_ Roommate \_\_\_\_ Pets \_\_\_\_ Alone \_\_\_\_ Others \_\_\_\_\_
37. Which of the following describes your marriage/significant relationship? \_\_\_\_ Very Satisfied \_\_\_\_ Satisfied \_\_\_\_ Dissatisfied  
\_\_\_\_ Extremely Dissatisfied \_\_\_\_ No Current Relationship
38. Please check any of the problems that you may be having in your marriage/relationship: \_\_\_\_ Recently Ended \_\_\_\_ Too much  
arguing \_\_\_\_ Poor Sexual Relations \_\_\_\_ Spouse has physical problems \_\_\_\_ Jealousy \_\_\_\_ Financial Problems \_\_\_\_ Spouse has a  
problem with the law \_\_\_\_ Lack of Trust \_\_\_\_ Spouse has problems with affairs \_\_\_\_ Have few or no common interests \_\_\_\_ Spouse  
has/has had Drinking Problems \_\_\_\_ Cannot Share or Discuss Problems \_\_\_\_ Spouse is/has been Physically Abusive \_\_\_\_ Spouse  
does have/has had problem with drug abuse \_\_\_\_ Spouse has concerns about my drinking/drug use **Other** \_\_\_\_\_
39. Please check the problems that may apply to your children. \_\_\_\_ Behavior \_\_\_\_ School \_\_\_\_ Emotional \_\_\_\_ Medical \_\_\_\_ Legal  
\_\_\_\_ Drug/Alcohol \_\_\_\_ Other \_\_\_\_\_ None of These Listed \_\_\_\_\_
40. Do you feel you need vocational training, education or assistance with employment? \_\_\_\_ Yes \_\_\_\_ No
41. Which of the following have been work problems? \_\_\_\_ Missing Work \_\_\_\_ Work Related Injuries \_\_\_\_ Changing Jobs Often  
\_\_\_\_ Workman's Compensation \_\_\_\_ Problems Getting Along with Co-Worker \_\_\_\_ Problems Getting Along with Boss  
\_\_\_\_ Pending Disability Claim \_\_\_\_ Fired From Job \_\_\_\_ Never Employed  
Other \_\_\_\_\_ No Work Problems \_\_\_\_\_
42. Did the problems that you have/had at work involve alcohol/drug use? \_\_\_\_ Yes \_\_\_\_ No

\_\_\_\_\_  
**Psychologist Signature**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date**

**Charis Institute for Psychological and Family Services**  
21 Southgate Court, Suite 101  
Harrisonburg, VA 22801

**Phone: 540.568.1876**  
**Fax: 540.574.6076**

### **Client Information**

We would like to take the opportunity to let you know about some very important aspects of the services we will be providing for you at Charis. We would also like you to signify your acceptance of these arrangements by signing this form during the first visit you have with your therapist.

#### **Confidentiality**

Your identity and any information shared by you will be held in the strictest confidence. The right to release information about you belongs to you. No information, including the fact that our office is seeing you, will be released to anyone without your written or verbal permission. We will ask you to sign a release if we agree that this is necessary. Exceptions to this confidentiality policy are made as a result of legal requirement to report any of the following:

- The abuse or neglect of a child or dependent adult.
- Imminent danger of hurting yourself or someone else.
- In the case of court involvement, if the court would order it.
- Information regarding your involvement in treatment (i.e. Dates of treatment and billing records) if legal collection action becomes necessary by our office.
- Information regarding your treatment, dates of service, diagnosis, and treatment plans if you submit claims for these services to your insurance company and your insurance company requires such information.
- For the purpose of ensuring quality services, our staff is involved in on-going training and supervision. For this reason, confidential information will be shared among staff to enhance therapeutic effectiveness. Sessions may be audio taped or videotaped (with additional consent from you) with the goal of enhancing therapeutic effectiveness, and these tapes will be treated with the same level of confidentiality as other clinical records.
- For the purpose of scheduling appointments and receiving notice of cancellations when necessary, you give permission for us to leave a message at your home or work with numbers to call.
- Unethical or illegal practices of a psychologist.

#### **Appointments and Fees**

- You will see your therapist on an appointment basis. If you request this, where possible, we will try to establish a regular time for your appointments to make it more convenient for you. You should check with the office before your session or before you leave to confirm your next appointment.
- **Please notify us at least 24 hours prior to your appointment if you cannot keep your scheduled time. If we do not receive a 24 hour notice for a cancellation or if you do not show up for your appointment, you will be charged a \$35 fee and we will remove any future appointments you have scheduled.** After two cancellations with insufficient notice or two "no shows," you will be given a referral elsewhere. If you are a new client and do not show up for your first appointment, you will not be rescheduled. Insurance will not pay for "no show" fees, and you are responsible for payment.
- **There is a charge of \$200.00 for your first session** (which involves various intake procedures.) **Subsequent sessions are \$130.00 for 40-45 minute sessions** (other session fees available upon request). **You agree to pay in full for services not covered by your insurance and for your portion of covered services.** We will file insurance claims for you if you wish. If you file your own claim, and pay in full at the time of service we will give you a 25% discount. We will also give the same discount for those who do not have insurance and wish to pay cash at the time of the

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- visit.
- Telephone consultations are necessary at times and we want to make that available to all of our clients; however, anything over ten minutes will be on a prorated basis. *Insurance companies do not pay for telephone consultations.* If I need professional help between sessions, I agree to call the Charis office at 540.568.1876 and either someone in the office or the answering service will contact the therapist. I understand that the therapists do not carry beepers, and if I should need assistance and be unable to reach the therapist, I agree to go for help to the Rockingham Memorial Hospital Emergency Room, or to a Hospital Emergency Room near me. If I am unable to do so, I agree to call 911 for assistance.
- You may request copies of your notes, reports, or any other information that we have concerning your records. At times it is necessary for the clinicians to write reports concerning your treatment. Please know that there will be a small fee for processing any of the above.
- **We will provide you with a regular statement on your account. You agree to pay 1.5% interest (18% per year) on a balance that is 120 days or more past due. We understand that due to conditions of employment, health, or other factors, a payment plan or other necessary arrangement will need to be made. If this should occur please bring this to the attention of the Accounts Manager to avoid collection action. If collection is necessary you will be charged the collection fees in addition to your account balance.**
- If I should be dissatisfied with the services I receive, I agree to discuss this with my therapist and express the extent of my dissatisfaction. I understand that I may terminate treatment at any point, and may request a referral to another qualified therapist. In the event that I should make an ethical or legal complaint to any source regarding treatment rendered, and it is determined that the therapist is not found in error, I understand that I am liable for reimbursement of any costs incurred and income lost by the therapist in pursuing the matter.

#### Informed Consent to Treatment

I give my consent for the provision of psychotherapy and/or psychological evaluation services to **myself/my child** \_\_\_\_\_. I have read the policies and procedures on the preceding pages and I have discussed with my therapist any area(s) I do not understand. I agree to these provision. I understand that this consent will continue in effect as long as the individual noted above continues in treatment, unless I should notify my therapist in advance in writing that, as of a certain date, I am no longer consenting to further treatment, or any of the provisions listed above. I may request a copy of this form for my own records.

**My therapist will discuss with me the specifics of my treatment plan in our intake session.** I understand and am satisfied with my therapist's qualifications to treat the difficulties for which I am seeking help. I understand that my therapist will conduct him/herself in a manner consistent with ethical, legal, and professional standards of practice. **If I have any concerns, it is my responsibility to communicate these to my therapist.**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Client/Guardian Signature) (Date)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Psychologist Signature) (Date)

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**Authorization to Disclose Information  
to Primary Care Physician**

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. Until I revoke my consent, this authorization is valid.

I hereby authorize on behalf of myself/my child \_\_\_\_\_

**Please Check One:**

\_\_\_\_\_ To release or to exchange any applicable information with my Primary Care Physician.

\_\_\_\_\_ To release or to exchange medication information only with my Primary Care Physician.

\_\_\_\_\_ Not to release or exchange any information to my Primary Care Physician.

\_\_\_\_\_  
(Patient or Patient's Guardian, please sign)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Please print the name signed above)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Psychologist Signature)

\_\_\_\_\_  
(Date)

**Primary Care Physician's Name, Address & Phone**

\_\_\_\_\_  
(Please Print Physician's Name)

\_\_\_\_\_  
(Street/Mailing Address)

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(Zip)

\_\_\_\_\_  
(Area Code)

\_\_\_\_\_  
(Phone)

**Release/Exchange of Information**

I, \_\_\_\_\_, authorize Charis Institute regarding myself /child \_\_\_\_\_ to \_\_\_\_\_

(Name of self and child)

\_\_\_\_\_ Release information *including* medical, psychiatric, alcohol and /or drug abuse, HIV testing, and /or AIDS information to  
\_\_\_\_\_ Receive information, *excluding* medical, psychiatric, alcohol and/or drug abuse, HIV testing, and/or AIDS information from  
\_\_\_\_\_ *Exchange* information on an ongoing basis with:

(Name of individual or agency) Phone

**This information will be released for the purpose of:**

- \_\_\_ obtaining information
- \_\_\_ exchanging information with the above agencies
- \_\_\_ evaluating service needs
- \_\_\_ developing and maintaining a treatment plan
- \_\_\_ ongoing service coordination
- \_\_\_ continuity of care
- \_\_\_ psychological evaluation

**The specific records/reports to be disclosed shall include:**

- \_\_\_ Complete Records (including progress notes)
- \_\_\_ Discharge Summary
- \_\_\_ Psychological Evaluations
- \_\_\_ Psychological Records
- \_\_\_ Medical Records
- \_\_\_ Psychiatric Evaluation
- \_\_\_ School Records
- \_\_\_ Other -Specify type: \_\_\_\_\_

*I understand that the records and information released/exchanged shall be regarded as confidential communication except when public safety is threatened or when a release of such information is court ordered. I further understand that the purpose of this release is to assist the staff of Charis Institute to plan, implement, and to conduct follow up evaluations on the outcome of the counseling program. I know that I may request to receive a copy of this authorization. I agree that this authorization shall be valid for two years from the date in which I sign it and that a photographic copy of this authorization shall be as valid as the original. I understand that I may revoke this release /exchange of information in writing.*

*Alcohol, drug, HIV, ARC, and /or AIDS information, if present, will be disclosed from records whose confidentiality is protected by Federal Law which prohibits any further disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. Copies or faxes of this authorization are acceptable. I understand I may be charged a service fee for requesting copies of any records.*

\_\_\_\_\_  
**Patient signature (if over 14 years of age)**

\_\_\_\_\_  
**Print name of person who released information**

\_\_\_\_\_  
**(Patient/Guardian, or authorized signature if patient is a minor)**

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
**(Date)**

\_\_\_\_\_  
Psychologist Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
(Date)