PeaceWay CMS
Counseling & Mediation Services, Inc.

Authorization to Release Information

• Most clients have family members and friends in their ecology that occasionally become involved in their care. For example, your spouse calls to confirm/cancel your appointment time; OR your adult child calls with questions about your treatment progress; OR a friend, who helps you, calls because they are concerned about you. You have a right to request that PCMS restrict how protected health information about you is used or disclosed.

• ***Due to privacy regulations***, we cannot speak to anyone but the client unless we have your written permission. If you have anyone that you would allow us to communicate with, please list them below.I give PeaceWay Counseling & Mediation Services, Inc. (PCMS) staff my permission to speak with the following individuals regarding my care: (If you prefer that we NOT speak with ANYONE, please write NO ONE across the lines below). **Name of Family or Friend Relationship:**

Name : _____ Relationship: _____

Name : _____ Relationship: _____

Name : _____ Relationship: _____

Restrictions to Communications:_____

_____

I request that all communications (by telephone, mail or otherwise) by PeaceWay Counseling & Mediation Services, Inc. and/or its staff be handled in the following manner:

• For written communication: Address to:_____

_____

• For oral communication: Call: (Contact Person)_____

Home: _____Cell: _____

May we leave a message? ☐ Yes ☐ No

I understand that I have the right to revoke this authorization in writing at any time. I request that my confidential information be handled in the following manner and authorize PeaceWay Counseling & Mediation Services, Inc. staff to disclose information only to those individuals listed above and in the manner stated for oral & written communications.

Signature of Client or Guardian _____

If Guardian what relationship: _____ Date: _____/_____/_____

Signature of PCMS Staff reviewing policies _____

Date: _____/_____/_____