ACE
PSYCHOLOGICAL SERVICES, LLC
ADDICTION ♠ COUNSELING ♠ EVALUATION

Client Name:	Guardian: (if applicable)
Date of Birth:	Date of Request:

My signature below authorizes ACE Psychological Services, LLC to share or receive information with

_____

for the purposes of aiding in treatment recommendations and continuity of care.

Information obtained / released is for ☐ past 6 months ☐ past year ☐ past 5 years ☐ since earliest contact with the client

The following is information that may be released to ACE Psychological Services, LLC

☐ Attendance / Participation
☐ Assessment Results
☐ Alcohol / Drug Information
☐ Legal Status
☐ School Records
☐ Progress Notes
☐ Evaluations
☐ Treatment Recommendations
☐ Medical Records
☐ Psychiatric History
☐ Diagnosis
☐ Testing
☐ Consultation
☐ Medication List
☐ Other (specify)

The following is information that ACE Psychological Services may share

☐ Attendance / Participation
☐ Assessment Results / Summary
☐ Alcohol / Drug Information
☐ Biopsychosocial
☐ Progress Notes
☐ Evaluations
☐ Treatment Recommendations
☐ Other (specify)
☐ Diagnosis
☐ Testing
☐ Consultation

I understand that I may revoke my consent to release this information at any time except to the extent that action will have been taken or information released prior to the revocation of my consent. I understand that treatment is generally not a condition of my signing an authorization. This authorization form is valid for one year from signing date or unless otherwise revoked by me (client). If I am court ordered, this authorization will be in effect until I am released from court order or the last day of my probation.

Client (print) :_____Date:_____

Client (signature):_____Date:_____

Clinician:_____Date:_____