1st Step Counseling
1525 Western Ave, Ste. 4
Albany NY 12203-3536
(518) 629-5409

CONSENT TO THE RELEASE OF TREATMENT INFORMATION

Full Name:

Purpose of release:

Name and Address of Person(s) to Whom this Information Will Be Disclosed: Progress in treatment, diagnosis, assessments, treatment goals:
I understand that:

This authorization may include disclosure of information related to alcohol and drug treatment, mental health treatment, and confidential related information. The information that can be shared in person, phone, fax, mail, and email.

With some exceptions, health information, once disclosed, may be re-disclosed by the recipient. If I am authorizing the release of mental health, alcohol and drug treatment, or HIV/AIDS-related information, the recipient is prohibited from re-disclosing such information. The recipient is prohibited from using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the NYS Division of Human Rights at 888-392-3644. This agency is responsible.

I have the right to revoke this authorization at any time orally or written. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. This consent expires upon termination of treatment services with Our Village Services LLC.

Signing this authorization is voluntary. I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

Electronic Signature:

Date: