Authentic Pathways
Counseling & Consulting

AUTHORIZATION TO RELEASE INFORMATION

4773 Carroll Cemetery Road, Carroll, OH 43112
PH# 614-706-0975 Fax# 740-422-1548

_____ _____ _____ _____
Name of Patient (at time of service) Date of Birth Social Security Number

This release will include DRUG or ALCOHOL history, treatment, and/or diagnosis unless specifically excluded. I authorize Authentic Pathways Counseling & Consulting and its clinical and professional staff to:

☐ Release info to the following ☐ Release info from the following Or ☐ Exchange info with the following

_____
Name/Title/Facility

_____
Street Address

_____
City/State, Zip Code

Ph#_____ FAX#_____

Specifically requested Record Content:

☐ Discharge Summary/Termination Summary
☐ Psychiatric/Psychological Evaluation
☐ Labs
☐ Other, specify: _____
☐ Medical Information
☐ Date of Psychotherapy Session(s)
☐ Summary of clinical Progress

Record Information NOT to be released: _____

The purpose of this release:
☐ Insurance/Third Party Payment
☐ Continuity of Care
☐ Safety Planning/Intervention
☐ Other, specify _____
☐ Pending Legal Action
☐ Assist in Evaluation & Treatment

This authorization shall expire **180 DAYS** from the date of signing, and is subject to revocation by the patient at any time prior to the expiration date, but not made retroactive to any information already released. The request to retract this release shall be in writing, signed, dated, and sent to Authentic Pathways Counseling & Consulting.

I, the undersigned, hereby acknowledge that I have read this authorization prior to its execution and fully understand the nature of this release. **Note: A minor with a substance abuse diagnosis** must sign to approve the release of record information.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Signature of Witness Date

Note: There may be an administrative fee for copying records for purposes other than continuity of patient care

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Fee Schedule for Joshua Culbertson, LPC

Description of Service	CPT Code	Length of Time	Fee
Crisis Session, Short Session	90832	30 mins	$35.00
Regular Therapy Session	90834	45 mins	$45.00
Extended Therapy Session	90837	60 mins	$65.00
Family Session w/o Client	90846	45 mins	$65.00
Family Session w/ Client	90847	45 mins	$65.00
Intake/Diagnostic Session	90791	60 mins	$75.00