

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

Client Name: \_\_\_\_\_

Client ID: \_\_\_\_\_



Per agency policy, the above client was asked to sign Authorizations to Release Information between Brighter Futures Counseling, PLLC and his or her Primary Care Physician as well as any previous Mental Health Providers the client may have seen. The purpose of these authorizations is to allow the parties to discuss the client's treatment needs. However, the client and/or guardian declined to sign the requested authorizations. The undersigned recommended that the client and/or guardian discuss this with their Brighter Futures Counseling, PLLC provider to better understand the reason for the authorization. The provider will consult with office support should the client and/or guardian decide to sign the authorization in the future.

Authorizations to Release Information were requested by Brighter Futures Counseling, PLLC to the following providers; however, client declined to sign the authorizations:

- Client's Primary Care Provider \_\_\_\_\_
- Client's Previous Mental Health Provider(s) \_\_\_\_\_

Client reasons for declining to sign requested authorizations:

- Client declined to allow Brighter Futures Counseling, PLLC staff to discuss information with client's Primary Care Physician
- Client declined to allow Brighter Futures Counseling, PLLC staff to discuss information with client's previous Mental Health Provider(s)
- Client States they do not have a current Primary Care Provider
  - Referral information was provided to client about local Primary Care Providers
- Client States they have not seen any other mental health or substance abuse Providers in the last 6 months.

Sincerely,

\_\_\_\_\_  
*Client or Guardian*

\_\_\_\_\_  
*Date and Time*

\_\_\_\_\_  
*Office Support*

\_\_\_\_\_  
*Date and Time*