AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the discloser and/or use of individually identifiable health information, as set forth below, consistent with state and federal laws concerning the privacy of such information. Failure to provide all information requested may invalidate this Authorization.

I hereby authorize the use or disclosure of my health information as follows:

Consumer Name: _____ ID#: _____ DOB: _____

Persons/Organizations authorized to exchange information with Conflict Management Institute:
_____

_____

Purpose of requested use or disclosure: _____

This Authorization applies to the following information (select only one of the following):

- ❑ Only the following records or types of health information (including dates):
  _____

  _____
- ❑ All health information pertaining to any medical history, mental or physical condition and treatment received, except:
  _____

  _____
- ❑ All health information pertaining to any medical history, mental or physical condition and treatment received.

This Authorization expires (insert date or event): _____ or: ☐ one year from today's date.

NOTICE OF RIGHTS AND OTHER INFORMATION
I understand I may refuse to sign this Authorization. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this Authorization. I may take back ("revoke") this Authorization at any time in writing, signed by me or on my behalf, and delivered to the above address. I understand that revocation will be effective upon receipt, but will not affect actions already taken on the basis of this Authorization. I understand I have the right to receive a copy of this Authorization. Except as set forth below with respect to drug or alcohol abuse records, information disclosed as a result of this Authorization could be redisclosed by the recipient and might no longer be protected by federal confidentiality laws. I understand I may inspect or obtain a copy of health information to be used or disclosed as permitted under federal or state law, by written request.

SIGNATURE _____ Date: _____

If signed by someone other than the Consumer, state your legal relationship: _____

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ACKNOWLEDGMENT OF RELEASE OF DRUG OR ALCOHOL ABUSE RECORDS
I acknowledge that records to be disclosed as a result of this Authorization may include records that are protected by federal and/or state laws applicable to substance abuse. I SPECIFICALLY AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION RELATION TO DRUG AND/OR ALCOHOL ABUSE. The recipient of drug and/or alcohol abuse information disclosed as a result of this Authorization will need my further written authorization to re-disclose this information.

SIGNATURE _____ Date: _____

If signed by someone other than the Consumer, state your legal relationship: _____