Release of Information

Authorization for the disclosure of Protected Health Information (PHI)

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Name of Person in which PHI information may be released: _____

Their Day Of Birth: _____ /_____/_____

Name of Intended Receiver/Agency in which PHI information may be released to and obtained:

_____

Address: _____

Phone: _____ fax: _____

	Mental Status/MSE		Psychiatric Assessment & Update		Progress
	Psychological Evaluation		Crisis Intervention		Drug/Alcohol Evaluation
	Discharge Summary		Treatment Plan & Update		Medication Administration
	Diagnosis		Psychosocial Assessment & Update		Agency Documentation
	Substance Use Assessment		Educational Testing		Background & History
	History & Physical Examination		Lab Results (EEG, EKG, XRAY)		Collaboration of Care
	Physicians Orders		Court Orders		Phone contact
	Therapists Orders		Consultation Reports		Other:

This signed release of information (unless revoked in writing) shall terminate 90 days from the date of discharge or one year from the date of signature, whichever is the latter. By signing this release and authorization, I acknowledge that the information to be release may include material that is protected by Federal Law and may contain Persona Health Information. My signature authorizes release of all such information. I also understand that this authorization may be revoked at any time by submitting a written request and it will be honored with exception of information that has already been released. I also understand that if the person/organization authorized to receive my information is not a health plan or a health care provider, the release information may no longer be protected y Federal Privacy Regulation.

Self/Guardian: X _____ date:_____

Witness:_____ date:_____