RELEASE OF INFORMATION

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION AND RECORDS

Client Name: _____ Date of Birth: _____
Address:_____
City: _____ State: _____ Zip: _____ Phone:_____

I hereby authorize and request provider _____
☐ To Release Information To: ☐ To Obtain Information From: ☐ Contact by Telephone / Fax / Email

Person/Organization: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Purpose for Disclosure:
☐ Treatment ☐ Legal ☐ Personal ☐ To Coordinate Care
☐ Other (specify) _____

Information to be Disclosed from Treatment Dates ___/___/_____ to ___/___/_____:

(**Initial** all that apply)

___ Office/Consultation Notes ___ Billing/Payment Records ___ Evaluation/Assessment
___ Description of Progress in Treatment ___ Progress Notes ___ Treatment Plan
___ Discharge Status/Summary ___ Medication History ___ Urine Drug Screens
___ Transition Plan ___ Nursing Assessments ___ Correspondence
___ Drug/Alcohol Treatment Records ___ History ___ Complete Record
___ Other (specify) _____

Authorization Term Date:
☐ 12 Months from Date Signed ☐ Other specific expiration date: _____(MM/DD/YY)

I understand that I may refuse or revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of my treatment with my provider, except, however, if my treatment with my provider is for the sole purpose of creating health information for disclosure to the recipient identified in this authorization, in which case they may refuse treatment if I do not

sign this authorization.

I understand that this authorization will remain in effect until the term of this authorization expires or I provide a written notice of revocation to the providers Privacy Office at the address listed within this form. The revocation will be effective immediately upon providers receipt of my written notice, except that the revocation will not have any effect on any action taken by provider in reliance on this authorization before it received my written notice of revocation.

I understand that information regarding my alcohol and/or drug treatment is protected by federal law under the Drug Abuse Prevention, Treatment, and Rehabilitations Act and the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and their implementing regulations. See generally 42 C.F.R. Part 2; 45 C.F.R. Parts 160, 164. I understand that my health information, as specified on this form, will be disclosed pursuant to this authorization, that the recipient of the information may redisclose the information and it may no longer be protected by federal law under HIPAA. Federal law governing confidentiality of alcohol and drug abuse patient information noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from redisclosure.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize provider to use or disclose my health information in the manner described above.

Patient/Guardian Printed Name: _____

Patient/Guardian Signature: _____ Date: _____

Signature of Witness: _____ Date: _____