AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ Date of Birth: _____

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting our office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, legal/ court records, educational records, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the above identified patient. I authorize these agencies to share information by mail, phone, in person, fax and/or email contact. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

I hereby authorize _____ to RELEASE my protected health information (PHI) to:

_____

I hereby authorize _____ to OBTAIN my protected health information (PHI) from:

_____

Disclosure Scope for PHI Release:

Disclosure may include the following verbal or written information: (check all that apply)
Face sheet History & physical
Laboratory/diagnostic testing results School information
Discharge summary Medication records
Behavioral health/psychological consult Psychosocial assessment/Family history
ER record report Psychiatric evaluation
Substance abuse treatment records HIV/AIDS lab results & treatment history
Progress & Case Notes Summary of treatment records & contact dates
Psychological evaluation/testing results Other:_____
Information necessary to identify, diagnose, prognosis, or treatment for mental health, substance abuse (alcohol/drug use), and any other relevant information for the purpose of treatment.

All information I hereby authorize to be obtained from the above identified source will be held strictly confidential and cannot be released by *Insert company name*, Inc. without my written consent. I understand that this authorization will remain in effect for:
The period necessary to complete all transactions on accounts related to services provided to me.
One (1) year
Other:_____

I understand that unless otherwise limited by territorial, state or federal regulation and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time. If client is a minor child, I verify that I am the legal guardian/custodian of this child.

_____ _____
Signature of Client/Legal Guardian or Legally Authorized Representative *Date*