AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: ______________________________ **Date of Birth:** ______________

I hereby request and authorize

____
Name of Individual/Organization   Address   Phone   Fax

TO RELEASE TO: ________ (Client Initials)   **OBTAIN FROM:** ________ (Client Initials)   **EXCHANGE WITH:** ________ (Client Initials)

____
Name of Individual/Organization   Address   Phone   Fax

The type and amount of information to be used or disclosed is as follows: (provide a specific and meaningful description of the information, including dates where appropriate)

_____Discharge Summary
_____Progress Notes
_____Master Treatment Plan
_____Educational Records
_____Psychological Testing
_____Medical Records/Reports
_____Other: ____
_____Psychological/Mental Status Assess.
_____Medical Assessment
_____Psychiatric Evaluation
_____Medication Update
_____Biopsychosocial Evaluations
_____Billing and Insurance processes
_____Social History
_____Treatment Issues
_____Referral For Med
_____Hospital Records

PLEASE NOTE: the client (and parent/personal representative, if applicable) must initial here ______ to authorize disclosure of records of alcohol/drug evaluation and treatment.

I have the right to inspect and copy any information being disclosed.

I understand I may revoke this authorization in writing at any time except for the extent that action has already been taken on this authorization.

This authorization will expire on the following date or event: ______________________________
Date   Patient Initials

If I fail to specify a date or event, it will expire in six months.

I understand that I can refuse to sign this authorization. I need not sign this authorization in order to receive treatment.

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may no longer be protected by federal confidentiality rules.

I have received a copy of this authorization.

______________________________   ______________________________
Signature of Patient   **Date**   **Signature of Witness**   **Date**

____
Signature of Parent/Personal Representative   **Date**

If the Patient is a minor (under age 18), both the Patient and Personal Representative must sign.

Nature of the Personal Representative's authority to act for the Patient: ______________________

NOTICE TO WHOMEVER DISCLOSURE IS MADE: If this information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2), the Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.