AUTHORIZATION TO RELEASE/OBTAIN/HOLD PATIENT INFORMATION

Client Name: _____ Date of Birth _____

Address: _____

_____

Phone: _____

Authorization to Disclose (client/guardian must initial appropriate item)

_____ I authorize clinician to release confidential client information to:

_____ I authorize the release of confidential client information to clinician from:

Agency/Person: _____

Address: _____

_____

Phone: _____

Purpose of Need for Disclosure (client/guardian must initial appropriate item)

_____ Continuity of Care

_____ Legal Proceedings

_____ Insurance (Third-Party Refund)

_____ Insurance (Application)

_____ Other, explain _____

_____ Social Security Disability Determination

_____ Medicaid Application

_____ Armed Services Application

_____ Personal Copy

Type of Information to be Disclosed (client/guardian must initial appropriate item)

_____ Any and all treatment records including evaluations of psychiatric, and/or psychological conditions, **alcohol and/or drug use**, treatment summaries, referral information, progress notes, lab tests including **HIV or AIDS** testing, medications, diagnoses and billing information.

_____ Other, specify any limitations _____

I understand this authorization will expire in 180 days from signing or when client is terminated from services, if prior to 180 days.

☐ _____, 20__, or

☐ On the happening of the following event: _____

_____ _____

Signature of Client
(Client must sign if alcohol or drug abuse is involved, even if client is under age 18)

Authorized Signature & Relationship to Client

Check Status: ___ Parent ___ Legal Guardian
___ Legally Assigned Custodian
___ Other _____

Date of Signature: _____ Witness: _____

Revocation/Expiration:

This authorization is not required as a condition of treatment and may be revoked at any time. However, revocation does **not** affect information released by this authorization prior to revocation, nor information to be released for billing purposes or other purposes according to law. Unless revoked, this authorization expires upon clinician's termination of client care and receipt of payment for all services.

Prohibition of Redisclosure:

This release does not authorize subsequent disclosure by its recipients. If the record contains drug or alcohol information, it may be protected by Federal Confidentiality Rules (42CFR Part 2). The Federal rules prohibit 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 (42CFR Part 2). A general authorization for the release of medical or other information is **not** sufficient for this purpose. The Federal rules restrict use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Revoked by: _____ Date: _____