AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

PATIENT: _____
FILE#: _____ **DATE OF BIRTH:** _____

1. I hereby give my permission to _____ or its employees or agents to exchange information from my records with:

NAME: _____
ADDRESS: _____
CITY_____**STATE**_____**ZIP**_____ **PHONE**_____

2. For the specific purpose of:_____

3. The following information/records may be released: (I understand that this information may include medical information, psychiatric, psychological, drug and/or alcohol records, and HIV tests/results except as specified below).

_____FACE SHEETS
_____DISCHARGE SUMMARIES
_____ASSESSMENTS:
_____PSYCHIATRIC
_____PSYCHOSOCIAL/FAMILY
_____NUTRITIONAL
_____HISTORY & PHYSICAL
_____ALL
_____CONSULTATION REPORTS
_____TREATMENT PLANS
_____OTHER:_____

_____ PROGRESS NOTES
_____ MEDICATIONS
_____ LAB/TEST RESULTS:
_____INCLUDING HIV
_____ EXCLUDING HIV
(NOTE: Checking either of these spaces does NOT indicate whether patient had HIV testing)

4. Manner of release (Check all that apply): _____ Fax _____ Written _____Verbal

5. This consent is subject to revocation at any time except to the extent that _____ or its employees or agents have already taken action in reliance on it. I understand that I am entitled to a copy of this consent. I hereby release _____, its employees and agents from any liability which may arise as a result of the use of any information contained in the records released. This authorization will expire 180 days from the date signed. I acknowledge that I have read this authorization, fully understand its contents, and have voluntarily signed it on this date. I may revoke this consent by mailing a written statement revoking this consent by certified mail to _____. A COPY OF THIS RELEASE SHALL BE AS VALID AS THE ORIGINAL. I understand that _____ may not condition the provision to me of treatment on whether I provide a consent, except that _____ may condition the provision of research related treatment on my providing a consent for the use or disclosure of protected health information for such research and _____ may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on my providing a consent for the disclosure of the protected health information to the third party.

_____ _____
SIGNATURE OF PATIENT **DATE** **SIGNATURE OF WITNESS** **DATE**

_____
SIGNATURE OF GUARDIAN OR REPRESENTATIVE (IF NEEDED)

_____
RELATIONSHIP OF GUARDIAN OR REPRESENTATIVE (PARENT; GUARDIAN; PERSONAL REPRESENTATIVE; COURT APPOINTED REPRESENTATIVE)

_____
DATE

PROHIBITION ON REDISCLOSURE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY LAW. ANY FURTHER DISCLOSURE IS STRICTLY PROHIBITED UNLESS THE PARTICIPANT PROVIDES SPECIFIC WRITTEN CONSENT FOR SUBSEQUENT DISCLOSURE OF THIS INFORMATION. THESE RECORDS MAY BE PROTECTED BY FEDERAL REGULATION (42 CFR, PART 2). FEDERAL RULES RESTRICT ANY USE OF THE INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ALCOHOL/DRUG ABUSE PARTICIPANTS.