AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I hereby authorize _____ or its agent(s) to disclose my health information as described in this authorization:

Client Name:_____Date of Birth:_____

SSN:_____Previous Name:_____

Please release health care information to/from:

Name and Organization:_____

Address:_____

City/State:_____Zip_____

Release the following information:

- ❒ Health care information relating to the following treatment or condition:_____
  _____
- ❒ Health care information for the following dates:_____
- ❒ All health care information:_____
- ❒ All health care information *excluding* the following:_____
  _____
- ❒ All mental health information, including assessment, diagnosis and treatment:_____
- ❒ Substance Abuse Evaluation done on the following date:_____
- ❒ Discharge Plan done on the following date:_____
- ❒ Results of drug screen done on the following date:_____
- ❒ Dates of attendance for individual or group therapy as follows:_____
- ❒ Other_____

Expiration of Authorization: This authorization will expire *(choose and complete one)*:

- ❒ In 90 days; or
- ❒ When the following occurs:_____
  _____

Right to Revoke: I may cancel this authorization in writing as allowed by law. This would not affect any actions already taken based upon my original request. There are three ways to cancel this authorization:

1) Sign and date a revocation form.
2) Write, sign and date a letter to the above agent at the following address:
   _____
   _____,
   ,requesting that the authorization be cancelled; or
3) Sign, date and write "CANCEL" on this original form.

Potential for Redisclosure: Once this information is released, the person/organization releasing it has no control over it. The recipient might re-disclose it. Privacy laws may no longer protect it.
Right to Copy: I understand that I am entitled to receive a copy of this authorization.

Voluntary: I understand that I am under no obligation to sign this form. I acknowledge I am voluntarily signing this form to release my health information to the party or parties I have designated.
Purpose of Authorization: I am requesting that my Protected Health Information be disclosed for the following purpose_____

_____

Or: ❒ I elect not to disclose the purpose of this evaluation.

Treatment not Conditional: I understand that my treatment is not conditional on whether or not I choose to sign this authorization.
Photocopy or Facsimile: A photocopy of facsimile of this signed authorization form shall be considered as valid as an original signed copy.

I have had an opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

Client or legally authorized individual signature	Date	Time
Witness Signature	Date	Time

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Complete the following only if you are a Personal Representative signing the form on behalf of the individual:

If a Personal Representative executes this form on behalf of the individual, the Personal Representative warrants that he or she has authority to sign this form on the basis of:

❒ A power of attorney for health care purposes including the right to access protected health information (copy attached).

❒ A court order of appointment as the conservator or guardian of the individual (copy attached).

❒ An individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law exceptions).

❒ Other:_____

PROHIBITION ON REDISCLOSURE

This information has been disclosed to you from records whose confidentiality may protected by Federal Law. Federal regulations may prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information may not be sufficient for this purpose. Federal Rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient (42 CFR Part 2 applies only to substance abuse records.)