Release of Information

Client's Name:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ DOB: _____

I, _____, authorize _____ to: _____ (send) _____ (receive) the following _____ (to) _____ (from)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR PSYCHOTHERAPY NOTES.

_____ Behavior programs
_____ Progress reports
_____ Medical reports
_____ Psychological reports
_____ Service plans
_____ Summary reports
_____ Entire record, except progress notes
_____ Others, specify _____

The above information will be used for the following purposes:

_____ Planning appropriate treatment or program
_____ Continuing appropriate treatment or program
_____ Determining eligibility for benefits or program
_____ Other (specify) _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states very, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to client: ____Self____Parent/legal guardian ____Other (describe) _____

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: _____ Date ____/ _____/ ____

Parent/guardians/personal representative (if applicable)

Signature: _____ Date ____/ _____/ ____

Witness

Signature: _____ Date ____/ _____/ ____