AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

Patient Name: _____ DOB: _____

INFORMATION MAY BE DISCLOSED/RELEASED BY:

Person/Facility: _____ Phone #: _____

Address: _____ Fax #: _____

INFORMATION MAY BE DISCLOSED/RELEASED BY:

Person/Facility: _____ Phone #: _____

Address: _____ Fax #: _____

Other method of communication: _____

INITIAL - I SPECIFICALLY AUTHORIZE RELEASE OF INFORMATION RELATING TO: Date Range: _____

_____ General Medical Records
_____ Mental Health
_____ Psychotherapy
_____ Diagnostic Test Results
_____ HIV/AIDS related information and treatment
_____ Sexually Transmitted Diseases
_____ Other _____
_____ All of my health information that the providers have in their possession, including information related to any medical history, mental health (excluding psychotherapy), or physical condition and any treatment received by me

_____ History & Physicals
_____ Progress Notes
_____ Substance Use Disorders
_____ Family Planning
_____ ***HIV/AIDS related information may be sent via fax***

PURPOSE OF DISCLOSURE: _____ Continuity of Care _____ Personal Use _____ Other (Specify): _____

EXPIRATION DATE: This authorization will expire (insert date or event) _____ .I understand that if I fail to specify an expiration date or event, this authorization will expire in twelve (12) months from the date on which it was signed.

Our Notice of Privacy Practices provides more details on uses and disclosures of your protected health information for treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information. You understand that the above information may be redisclosed by the recipient and may not be protected by federal privacy laws or regulations. Any information covered under 42 CF part 2 will not be redisclosed. You understand that completing this authorization form is voluntary and that treatment will not be denied if you refuse to sign this form. You may request a list of protected health care information disclosures made on your behalf.

You have the right to **revoke** your authorization by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this authorization. You are entitled to a copy of this **authorization form** after you have signed it.

_____ _____
Client Signature Date

_____ _____
Printed Name Relationship to Client

_____ _____
Witness (Optional) Date