AUTHORIZATION TO RECEIVE / DISCLOSE HEALTH INFORMATION

Client Name: _____

Date of Birth: _____

Person Authorizing Release: _____

Relationship to Client: _____

Recipient / Organization to Receive/Disclose:_____
(Name / Address / Fax / Email)

This data shall include (please check data to be received or disclosed)

- o Assessments
- o Psychiatric Evaluations
- o Psychological Evaluations
- o Diagnoses
- o Progress Notes
- o Treatment Plan / Goal
- o Discharge Summary
- o Financial Obligations
- o Substance Abuse/Treatment
- o HIV / AIDS Information
- o Other _____

Purpose of Release or Disclosure

- o At the request of individual
- o Court proceedings
- o Assessment / Evaluation
- o Determination of benefits
- o Coordination of Care

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

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Signature Page

Client Name (print) Date

Client signature

Parent / Guardian signature

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