AUTHORIZATION TO RELEASE INFORMATION FROM THE CLIENT RECORD

Client Name Date of Birth

I hereby consent and authorize:

Name of Provider: _____
Address: _____
Phone: _____ Fax: _____

to obtain from **and/or** release to:

Name of Organization and Contact Person: _____
Street Address: _____
City, State, and Zip Code: _____
Phone Number, including Area Code: _____
Fax Number, including Area Code: _____

I authorize the above-named provider(s) to release information about me as follows:

___ Presence in treatment (admit/discharge dates)
___ Diagnosis/brief description of progress/prognosis
___ Treatment plan
___ Psychosocial/Diagnostic Summary
___ Discharge summary/Aftercare plan
___ Psychiatric/Psychological consults
___ Educational discharge summary
___ Educational records, achievements, assessments
___ Legal history
___ EAP ***OR*** SAP attendance and provider's recommendations
___ DWI ***OR*** substance abuse evaluation results, education and/or treatment recommendations, and compliance in following education and/or treatment recommendations
___ Other: _____

This information is needed for the following purpose(s):

___ To provide ongoing services/treatment/continuing care
___ To obtain insurance, employment, government benefits
___ To coordinate treatment efforts with my family/concerned person
___ To coordinate treatment and continuing care efforts with my employer
___ To coordinate educational planning and re-entry program with school persons
___ To enable judges, attorneys, probation/parole officers to support treatment goals and make legal decisions on my behalf
___ To show compliance with EAP ***OR*** SAP supervisory referral
___ Other: _____

I understand that I need not consent to the release of information in order to obtain services. I choose to do so willingly and voluntarily for the purpose(s) specified above. The duration of this authorization is no longer than 365 days unless I specify a date, event or condition upon which it will expire. I understand that I may revoke this authorization at any time by notifying my provider in writing, except to the intent that action has been taken in reliance on my authorization.

Specify date, event, or condition upon which authorization expires other than 365 days from signing:
_____

Client Signature: _____ Date: _____

Parent or Legal Guardian Signature:_____ Date: _____

Legal Representative Signature: _____ Date: _____

Witness Signature: _____ Date: _____

ALL INCLUSIVE

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Additionally, these records are protected by 45 CFR Parts 160 and 164 (HIPAA).
rev. 02/27/08