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HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

______ Give Information To _____ Receive Information From

Client Name: ____ Date of Birth: ______________

Name of Agency/Professional: ____

Address: ____

Phone Number: ___________________________ Fax Number: ___________________________

I authorize and request the disclosure of all protected information for the purpose of review and collaboration to conclude the evaluation process. I request the designated record custodian of all covered entities under HIPAA identified above disclose the following information:

_____ Legal Records/History, Police Narrative/Reports
_____ Mental Health/Therapy Notes, Recommendations, Diagnosis
_____ Urinalysis Results
_____ Chemical Dependency Evaluations, Discharge Summaries, Recommendations
_____ Diagnostic/Psychological Assessment(s)
_____ Medical Notes
_____ ____.
_____ **All records for the period** _________________ to _______________.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), and human immunodeficiency virus (HIV). I authorize the release or disclosure of this type of information. This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

This protected health information is disclosed for the following purposes: case consult, evaluation collateral, ongoing care and service coordination.

I understand the following: See CFR §164.508(c)(2)(i-iii) (a) I have a right to revoke this authorization in writing at anytime, except to the extent information has been released in reliance upon this authorization. (b) The information released in response to this authorization may be re-disclosed to other parties. (c) My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until one year from date of execution at which time this authorization expires.

____ ______________________

Client Signature Date (See 45CFR § 164.508(c)(1)(vi))

____

Name and Relationship of Legally Authorized Representative to Client (See 45CFR §164.508(c)(1)(iv))