Release of Information

Name: _____

Address: _____

Phone: _____ Date of Birth: _____ ID #: _____

I authorize AGENCY, Inc. to: ☐ Release Information to and/or ☐ Receive information from:

Name of Entity _____

Address: _____

_____

For the purpost of continuity of care, I authorize AGENCY to provide copies of my protected health information as catgorized:

The confidentiality of alcohol and/or drug abuse client records maintained by AGENCY is protected by federal law and regulations. Except under special circumstances, AGENCY may not orally disclose to a person outside the program that a client attends the program. The program also may not disclose any information identifying the client's history of alcohol and/or drug abuse unless: unless by written authorization by the client; by written court order; or the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation process. (Federal Law references 42 U.S.C. 290 dd-3 and 42 U.S.C. 290 ee-3 - Federal Regulation reference CFR, Part 2)

I authorize AGENCY to disclose and/or receive medical information regarding my treatment to include any protected health information to/from the entity as indicated on this authorization form. This disclosure is necessary for continuity of care. I understand that federal laws protect the confidentiality of my alcohol and drug abuse medical records. I understand that I can revoke this authorization at any time in writing and that this authorization is valid for a six (6) month period from the date of my signature.

I understand that my protected health information (medical history) may be used and disclosed to carry out treatment, payment of services, or health care operations to improve quality of care by AGENCY and other medical professionals that provide care to me.

I acknowledge receipt of AGENCY Notice of Privacy Practices and I understand that I have the right to review the Notice before signing this consent. I understand any changes in the Notice are available to me upon request.

I understand that I have the right to request AGENCY to restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that AGENCY is not required to agree with my request. I understand that I have the right to revoke an authorization to release my protected health information in writing.

Consumer Name	Consumer Signature	Date
Legal Representative Name	Legal Representative Signature	Date
Witness Name	Witness Signature	Date