Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize: ( ) Dr. Mary Vaughn ( ) Dr. Melody Benson ( ) Dr. Rick O’Leary ( ) Dr. Colleen Leitner

 ( ) John Hayes ( ) Paula Kovarcik ( ) Erica Winn ( ) Cristin Sauter ( ) Brittany Dye

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Obtain** |  | **Client Initials** |
|  | **Release** |  | **Client Initials** |

( ) From ( ) To (Name & Address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following information under these conditions:

1. 1. A voluntary client can cancel the Consent in writing at any time except to the extent information has been released based upon the Consent.
2. The Consent shall be valid only for that period reasonably necessary to accomplish the purpose for which it is given.

In the case of:

1. Criminal Justice Client-60 days or until there is a “substantial change” in client’s status. Whichever is longer
2. Voluntary Client-until the client expressly cancels the Consent. When he/she does not expressly cancel the consent, it shall automatically terminate.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date, Event or Condition

Specific information to be released may include psychiatric, drug, abuse or alcohol treatment \_\_\_\_\_\_\_**(initials)**. It is my intent the recipient is prohibited from disclosing this information to any other party. I have read and understand all of the above. **Patient/Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I understand that my records are currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPPA), 45 CFR Parts 160 & 164. I understand that my health information will be disclosed pursuant to this authorization and that the recipient of the information may redisclose the information and it may no longer be protected by HIPPA privacy law. The Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, will continue to protect the Confidentiality of Information that identifies me as a patient in an alcohol or drug program from redisclosure. I understand the covered entity seeking this authorization is permitted under the HIPPA regulations, in accordance with the 45 CFR, Section 154.508(b)(4), to condition my signing of the authorization on the provision of treatment, payment, enrollment or eligibility for benefits and that by refusing to sign this authorization, I may be responsible for payment of services and/or may not be able to receive services.

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information to be released:

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Psychosocial History |  |  | Progress Notes |  | Consultation |  | Financial Information |  |  |
| Medical History |  |  | Psychological Testing |  | Phone Consultation |  | Lab Work |  |  |