



AUTHORIZATION FOR RELEASE OF INFORMATION

1. The undersigned hereby request and/or authorize:

to release the medical record of:

Name: _____ SS# - -

Birth Date: / / _____ Dates of Professional Service: _____

2. Information to be released to:

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

3. Information to be released – **check yes or no AND initial (may include substance use disorder records, if applicable).**

YES	NO	INFORMATION AUTHORIZED TO RELEASE	INITIALS	YES	NO	INFORMATION AUTHORIZED TO RELEASE	INITIALS
		Major Evaluations				Doctor Notes	
		Treatment Plans				Medications	
		Appointment History				Progress Notes	
I do authorize disclosure of my substance use disorder progress notes.							
		Other:					

4. Purpose of release:

Time limitation of Release and Revocation: This consent is subject to revocation at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization.

- I understand that I may **revoke this authorization at any time** by submitting a written revocation, except to the extent that action has already been taken in reliance on this authorization.

REDISCLASURE AND USE OF INFORMATION: Information disclosed under this authorization may include records protected by **42 CFR Part 2**. Recipients of this information may **further use and redisclose it for treatment, payment, and health care operations** in accordance with **HIPAA** and applicable federal law.

ANTI-DISCRIMINATION NOTICE: Federal law prohibits recipients of this information from **discriminating** against an individual based on the information disclosed, including substance use disorder information, in employment, housing, access to health care, or other services, consistent with applicable law.

THIS FORM MUST CONTAIN ORIGINAL SIGNATURES.

Signature of Client/Resident/Patient:	Date:	Signature of Consumer's/Resident's/Patient's Agent or Representative:
Signature of Witness:	Date:	Date: _____
		Relationship: _____
		Address: _____

This authorization shall remain valid and effective until revoked by the client. No automatic expiration date applies.

At the client's election, this authorization may terminate upon the occurrence of a specified event identified by the client.

Event: _____