AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Client Name: ______________________________ **Date of Birth:** ______________

(Last) (First) (MI) (Month / Day / Year)

I, ______________________________, authorize the following to access, use, or disclose my health information:

Agency:	______________________	(AND)	Agency:	______________________
Name:	______________________		Name:	______________________
Address:	______________________		Address:	______________________
	______________________			______________________
Phone:	______________________		Phone:	______________________
Fax:	______________________		Fax:	______________________

Form(s) of access/use/disclosure authorized:

☐ (______) Verbal
☐ (______) Written ☐ (______)Written (email)

Form(s) of access/use/disclosure authorized:

☐ (______) Verbal
☐ (______) Written ☐ (______)Written (email)

The following may be accessed/used/disclosed:

☐ (______) Assessments/Diagnosis
☐ (______) Psychiatric/Psychological Evaluations
☐ (______) Treatment plans/discharge summary
☐ (______) Progress Notes
☐ (______) Other ______________________

The following may be accessed/used/disclosed:

☐ (______) Assessments/Diagnosis
☐ (______) Psychiatric/Psychological Evaluations
☐ (______) Treatment plans/discharge summary
☐ (______) Progress Notes
☐ (______) Educational Records
☐ (______) Other

The following information may be accessed/used disclosed by the above:

☐ (______) All substance health information related to my medical, mental, physical condition and treatment except:

____

☐ (______) All HIV information related to my medical, mental, physical condition and treatment except:

____

Reason for release is (check all that apply):

☐ (______) At my request
☐ (______) To facilitate diagnosis, evaluation, treatment planning, and treatment
☐ (______) To assist in the application process for benefits for which client may be entitled
☐ (______) Other (specify): ______________________________

This authorization ends: ☐ (______) on date: ☐ (______) when the following occurs:

My Rights (read before signing):

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). However, that I do have to sign authorization to take part in a research study or to receive health care when the purpose is to create for or release health information to a third party. I understand I may revoke this authorization at any time provided it is in writing although it would not affect any actions already taken by the above based on this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. By signing this authorization, I am waiving my rights, if any, to confidentiality as indicated above. Although bound by the same privacy laws, I understand once Arbor Behavioral Services, LLC discloses information the receiving party may re-disclose which Suba Psychiatry/Park Psychiatry has no control. **A photocopy of this consent shall be considered as valid as the original and will be electronically stored.**

Client/Legal Guardian Signature: ______________________________ Date/Time: ________ / ________

Printed name (if legal guardian) ______________________________ Relationship:

To receiving party: The attached information has been disclosed to you from records protected by Federal confidentiality rules (42 CFT 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 the 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.