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Authorization of Release of Information (HIPAA)

I, ____ SS Number ____________________
Name

____
(Address)

hereby authorize ____

to release ____
(Specific Nature of Information to be Disclosed)

about ____
(Name of Client)

To Spouse Children Other Information is not be released to anyone
(other is only to be used for releases of information related to alcohol and drug

For the Purpose of:

Continuing (behavioral health/mental health/alcohol and/or drug abuse) treatment/care and continuity of care
- ☐ Therapist transition
- ☐ Billing and payment related matters
- ☐ Other ____

For messages you may call:
Cell ____________________
Work ____________________
Home____________________

If unable to reach me select one for each:
Leave a detailed message
Return Call
Do Not Leave a Message

This consent is valid until terminated by me________________________ in writing. I understand I may revoke this consent at any time and the above-named person authorized to receive this information has the right to inspect and copy the information to be disclosed and to use the information for the purposes outlined above.

Notice to Client and Receiving Agency – Under the provisions of the Mental Health and Developmental Disabilities Confidentiality Act and Applicable Federal and State Alcohol and Substance Abuse Confidentiality acts, there may not be redisclosure of any of the information provided pursuant to this release unless the patient and/or parent of the patient specifically authorizes such disclosures.