

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Client Name: _____ DOB: _____	Person making request: _____ Relationship: _____
Agency/Person to Release or Receive Information: School Name: _____ Address: _____ Phone # _____ FAX # _____ <i>FAX transmission authorized, if needed? YES ___ X ___</i>	Agency/Person to Receive or Release Information: Name: _____ Address: _____ Phone # _____ FAX # _____

This information is requested for the following purpose: ☐ Continuity of care ☐ Application/reapplication for benefits ☐ Disability determination ☐ Legal proceedings ☐ Other (specify): _____ Behavioral Support Planning _____ ☐ WRITTEN INFORMATION ONLY ☐ VERBAL INFORMATION ONLY ☐ WRITTEN AND VERBAL INFORMATION	The minimum necessary information to accomplish the purpose is: ☐ Medications ☐ Treatment Plan ☐ Progress Notes ☐ Discharge Summary ☐ Form Completion ☐ Letter regarding ☐ Assessments ☐ Lab ☐ Referrals ☐ Provider Discharge ☐ IEP ☐ 504 ☐ Tier 2/Tier 3 behavior intervention ☐ Safety/Crisis Plan
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READ CAREFULLY My signature below acknowledges my understanding of the following: 1. I understand that medical/behavioral health records are confidential. By signing this authorization I am allowing the release of information, including any substance abuse information to the agency or person specified above. Transfer of the information released above to persons or agencies not specified is prohibited by law. 2. I understand that signing this authorization is not a condition of receiving treatment here. 3. This authorization includes both information presently compiled and information to be compiled during the course of the client's treatment at this agency. 4. I understand that there is a potential for the information disclosed to be subject to redisclosure by the recipient and no longer protected by this law. 5. This consent is subject to revocation by the undersigned at any time by completing the notice of revocation at the bottom of the page. Any actions taken before revocation will not be affected. 6. This consent to release information (unless revoked earlier) will automatically terminate one year from the date of signing, or six months from the date of signing if the purpose is for other than treatment. 7. Specify any special conditions, date, events that would result in revocation. _____ 8. I understand that I have the right to receive a copy of this authorization and to request to see or copy the information to be disclosed. 9. This authorization to release information is subject to the following restrictions: _____	
SIGNATURE: Patient Signature _____ Parent or Legal Guardian/Custodian _____	Date: _____ Date: _____

NOTICE OF REVOCATION – This revocation cancels my authorization given above.

SIGNATURE: Patient Signature _____ Parent or Legal Guardian Custodian _____	Date: _____ Date: _____
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Note: A copy of this authorization is as valid as the original.

CLIENT NAME: _____ **ID #:** _____

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