

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Use this form if the Client requests ongoing release OR if request is from someone other than the client or their legal representative

Client Name: _____ **D.O.B.:** ___/___/___ **Client #:** _____

I authorize South Central Human Relations Center to **send** **request** the private data specified below to/from:
 (A fee may be charged)

Name/Entity/Category: _____

Address _____ City _____ State _____ Zip _____

Email: _____ Encrypted: I understand the risk and request unencrypted:

Fax: _____ Phone: _____ HIE/PHR: _____

Information to be Released: Ongoing or Date from _____ to _____ or specific visit date: _____

- | | | |
|--|---|--|
| <input type="checkbox"/> Diagnostic Assessment | <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Testing results |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Verbal information | <input type="checkbox"/> Psychological Reports |
| <input type="checkbox"/> Letter(s) | <input type="checkbox"/> Other (specify) _____ | |

You must specifically request the following in order for it to be released:

- Chemical Dependency Program
- Psychotherapy Notes (conversational analysis) No other items can be checked when requesting this item

Reason: Assessment and Treatment Planning Continuity of Care
 Other (specify, e.g. legal, appeal SS Disability, marketing) _____

Valid for: One year or for this specified period: _____

This authorization **does** **does not** extend to information placed in my record after the date I sign this form.

- I understand that my records to be released may contain information regarding substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS-related information.
- I understand that I have the right to revoke this authorization by signing "I revoke..." below and returning to SCHRC. If South Central Human Relations Center has already released information based on this consent, we cannot retrieve what has already been released.
- I recognize that the protected health information used or disclosed according to this authorization may be re-disclosed by the recipient and SCHRC can no longer protect it.
- I understand that I may refuse to sign this consent, if I so desire, and that SCHRC may not refuse treatment if I do not sign, but refusal may have consequences that have been explained to me.

Signature: _____

Indicate if you are: Client, Parent, or Personal Representative (Provide legal proof if representative not parent) _____ Date _____

 Type of identity verification

I **revoke** this authorization: _____ /___/___

White copy to SCHRC, Yellow copy to Patient Signed 11/01/2018 Date _____