☐ **901 Bldg:** Connections / PHP ☐ **LH:** Coed / W&C-LS ☐ **South:** CG ☐ **Loma Vista:** AFS
☐ **Flory- Bldg A:** Children's Svcs / Outreach ☐ **Flory- Bldg C:** Access &Therapy / Med Clinic ☐ **TOP** ☐ **Transitions**
☐ **Linwood:** Women & Children / Alt-Care / USDC ☐ _____

Client Name:_____ Date of Birth:_____

I authorize ***ReDiscover*** to: ☐ Disclose to ☐ Request from

Name:_____ Phone #:_____

Address:_____ Fax #:_____

the following information relative to treatment received from: _____ to _____
Start date of services requested End date of services requested

PLEASE CHECK REQUESTED ITEM(S):

☐ Face Sheet ☐ BPS / Comprehensive Assess. ☐ Psychiatric Evaluation ☐ Health Assess. (Medical Info)
☐ Intake Assessments ☐ Interpretive Summary ☐ Medication Records ☐ Progress Notes
☐ Diagnostic Review ☐ Treatment Plan/ Reviews ☐ Lab Results ☐ Discharge Summary
☐ Other:_____
☐ Verbal / Written communication with:_____

* I understand that my drug and/or alcohol treatment records are protected under the Federal regulations governing Confidentiality & Drug Abuse Patient Records, 42 C.F.R. Part2, & the Health Insurance Portability Act of 1996 (HIPAA), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.
* I understand that the information in my record may include alcohol, substance abuse, or HIV status information.
  If you wish for Drug/Alcohol Abuse information to ***NOT*** be released, please sign and date here:_____
  Name Date
  If you wish for HIV information to ***NOT*** be released, please sign and date here:_____
  Name Date
* The purpose or need for disclosure of the requested information is:_____
* This authorization for release of information shall expire on _____ or one year after the date signed if not specified.
* I understand that I may revoke this authorization at any time, except to the extent of action that has already been taken. This may be accomplished by submitting my request in writing to the Privacy Officer.
* I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. This mental health facility, its employees and/or physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
* I understand that generally ReDiscover may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or otherwise permitted by 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 client.

_____ _____
Signature of Client or Authorized Representative Date

_____ _____
Staff Completing/Assisting with Release (Please Print) Unit/Location Staff Phone #

Client' Name:_____ MR#:_____

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

ReDiscover

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