AUTHORIZATION TO RELEASE AND EXCHANGE MENTAL HEALTH INFORMATION

COMMUNITY REACH CENTER

TIER: _____ **MRN:** _____

Consumer name: _____ **DOB:** _____
(MM/DD/YYYY)

Release To/From: The following organizations/ providers are hereby authorized to release, exchange, and share oral and written mental health information with each other, regarding the Consumer named above:

Community Reach Center

Release To/From:
Company/Organization/Person and Relationship: _____

_____

_____
Address:

(_____) _____ – _____ (_____) _____ – _____
Phone: **Fax:**

_____
Email:

Purpose(s) or need for which the information is to be used and disclosed: (Please check all applicable)

- ❑ Personal Use
- ❑ Benefits Coordination/Acquisition
- ❑ Disability Determination
- ❑ Service Planning
- ❑ Legal Purposes
- ❑ Assessment
- ❑ Coordination/Continuity of Care
- ❑ Payment of Insurance Claims
- ❑ Other (Specify): _____

Information to be released, exchanged, and shared: (Please check next to the documents to be released & exchanged)

- ❑ Assessments/Intake
- ❑ Legal Records and Information
- ❑ Progress Notes/Summary
- ❑ Psychiatric/Psychological Evaluations
- ❑ Medication History
- ❑ Monthly Reports
- ❑ Treatment/Service Plans
- ❑ Discharge Summaries
- ❑ Other (Specify): _____

Please initial the below statements:

_____ *Initial*
I UNDERSTAND and WILLINGLY RELEASE information requested that may include evaluation, diagnosis or treatment information regarding the following conditions: **alcohol or drug abuse**, and/or **HIV/AIDS**. I understand that this information may include, when applicable, information relating to sexually transmitted diseases including Human Immunodeficiency Virus (HIV Infection, Acquired Immune Deficiency Syndrome, or AIDS related Complex) and any other communicable diseases. It may also include information about behavioral or mental health services, and referral and or treatment for alcohol and drug abuse (as permitted by 42 CFR Part 2).

_____ *Initial*
I UNDERSTAND that I may revoke this Authorization at any time by giving written notice to the Center, except to the extent that the Center has already taken action on this request. This Authorization will expire on _____ (date), or, if left blank, **TWO YEARS** from the date of my signature (whichever event comes first). I release the Center from all liability for disclosing the requested information.

NOTICE TO THE RECIPIENT OF THE INFORMATION

This information has been disclosed to you from records protected by federal confidentiality rules/HIPAA Privacy Regulations. This prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted in written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 or 45 CFR Part 164. A general authorization of 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.

AUTHORIZATION: I understand that authorizing the disclosure of this information is voluntary. This Authorization may be used and re-used to obtain information learned and records prepared after the date this release was signed as long as this Authorization remains valid. I understand that when information is released, it carries with it the potential for unauthorized re-disclosure and it may no longer be protected by federal confidentiality rules such as HIPAA. A copy or facsimile of this Authorization may be used with the same effectiveness as the original.

_____ _____
Consumer OR PERSON AUTHORIZED TO SIGN FOR CONSUMER **Date**

_____
Print name if not the Consumer and state how authorized to sign

_____ _____
WITNESS SIGNATURE and Printed Name **Date**

_____ *Initial*
I attest that I have legal guardianship of the above Consumer and/or have authority to make medical decisions on their behalf.