

# AUTHORIZATION TO RELEASE AND EXCHANGE PROTECTED HEALTH INFORMATION



Nextgen MRN: \_\_\_\_\_

Consumer name: \_\_\_\_\_

DOB: \_\_\_\_\_  
(MM/DD/YYYY)

**Release To/From:** Community Reach Center is hereby authorized to release, exchange, and share oral and written health, mental health, and substance use disorder treatment information with the entities named.

**Release To/From:**  
Company/Organization/Person/Class of Persons: \_\_\_\_\_

**Address:**  
(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Email:** \_\_\_\_\_

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Personal Use or As Requested      | <input type="checkbox"/> Assessment                         | <input type="checkbox"/> Other (Specify): |
| <input type="checkbox"/> Benefits Coordination/Acquisition | <input type="checkbox"/> Coordination/Continuity of Care    |   |
| <input type="checkbox"/> Disability Determination          | <input type="checkbox"/> Payment of Insurance Claims        |   |
| <input type="checkbox"/> Service Planning                  | <input type="checkbox"/> Treatment, Payment, and Operations |   |

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

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Assessments/Intake                    | <input type="checkbox"/> Medication History      | <input type="checkbox"/> Other (Specify): |
| <input type="checkbox"/> Legal Records and Information         | <input type="checkbox"/> Monthly Reports         |   |
| <input type="checkbox"/> Progress Notes/Summary                | <input type="checkbox"/> Treatment/Service Plans |   |
| <input type="checkbox"/> Psychiatric/Psychological Evaluations | <input type="checkbox"/> Discharge Summaries     |   |

## ACKNOWLEDGEMENTS:

**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). I understand that I have the right to request a list of entities to which my records have been disclosed pursuant to this authorization, in accordance with federal law.

**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:

- Insert Specific Date: \_\_\_\_\_  Other event (Specify): \_\_\_\_\_  Upon Discharge from CRC

## NOTICE TO THE RECIPIENT OF THE INFORMATION

*This information has been disclosed to you from records protected by federal confidentiality rules/HIPAA Privacy Regulations. These records may not be used or redisclosed except as permitted by federal law 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. Unauthorized redisclosure of this information is prohibited. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient and prohibits discrimination against individuals on the basis of information disclosed pursuant to 42 CFR Part 2.*

**AUTHORIZATION:** I understand that authorizing the disclosure of this information is voluntary and will not affect my ability to receive treatment for refusal to sign. Refusal may impact the Center's ability to coordinate your care with other entities. 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. I have received or been offered a copy of this release.

\_\_\_\_\_  
**Consumer OR PERSON AUTHORIZED TO SIGN FOR CONSUMER**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print name (if not the Consumer) and state how authorized to sign**

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