Hope Behavioral Health, LLC

RELEASE OF INFORMATION AUTHORIZATION

I, _____(**Printed name of adult client, minor child's parent and/or legal guardian**) authorize Hope Behavioral Health, LLC's Therapist and the individuals or organizations listed below to have reciprocal communication about the type of disclosure checked and initialed.

_____

(**Name of individual and/or organization, I authorize to have reciprocal communication with Hope Behavioral Health, LLC)**

Regarding the Treatment Services of : _____

Print the Name of Client

Type of information to be disclosed, please check and initial all for which permission is being given:

_____**Mental Health Services**: Treatment Services Progress Reports, Diagnostic information and Treatment Services Reports and summary and recommendations for ongoing advocacy.

_____**Service Coordination** with other outside agencies as needed to improve overall level of functioning.

Mode of communication includes email; fax, mail, phone, and face-to-face: Hope Behavioral Health, LLC understand that alcohol and/or drug treatment records are protected under the federal regulations governing **Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2**. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. All health and behavioral health information is confidential and also protected by the **Health Insurance Portability and Accountability Act of 1996 (HIPPAA), 45 CFR Parts 160 & 164** and cannot be disclosed without the written consent of the client, unless otherwise provided for in the regulations. The client may revoke this consent, in writing, at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically (see*** Length of enforcement of Release of Information)**

**Length of enforcement of Release of Information: ***This Release of Information shall be enforce from the date signed and throughout the duration of treatment but no longer than for six (6) months following termination of services unless terminated in writing prior to that date.

I have read, reviewed and understand Hope Behavioral Health, LLC's Release Of Information Authorization.

I give my consent by signing below:

_____ Date:_____

Client Signature (18 or older)

_____ Date:_____

Parent/Legal Guardian (if Client is under 18)

_____ Date: _____

Staff Signature/Witnessed By