**Authorization for Release of Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize the release of my files and to share and exchange information under the limited conditions set forth below.

***To disclose the following health records (check all that apply):***

\_\_\_ Type of professional services rendered

\_\_\_ Dates on which professional services were performed

\_\_\_ Intake/termination Statements

\_\_\_ Diagnosis

\_\_\_ Treatment Plan and Recommendations

\_\_\_ Psychiatric Records

\_\_\_ Medical Records

\_\_\_ Alcohol, Substance, or other Addiction Treatment Records

\_\_\_ Laboratory Results

\_\_\_ other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I have the right to revoke this authorization except if I am signing this authorization in connection with my obtaining (1) a life or non-cancellable or guaranteed renewable health insurance policy, in which case, this authorization expires two years from the date of the policy, or (2) any other form of health insurance, in which case this authorization expires one year from the date of the policy.

I understand that the recipient of this information or records will keep them in strictest confidence, and may not re-release them to any other agency or individual without my consent.

This authorization applies only to any records of medical/mental health information that exists as of the date.

If the records or information being released involve treatment for alcohol or substance addiction, I understand that my records are protected by federal law and regulations relating to “confidentiality of alcohol and drug abuse patient records.” (42 CFR Part 2. 42 U.S.C. Section 29Odd-2). The federal regulations provide that my authorization to release information or records cannot be revoked if the program which is to make the disclosure has already taken action in reliance on it. An example would be if the program provided treatment services in reliance on valid consent to disclose information to a third party payer.

 The federal regulation also requires that this authorization terminate on a specific date.

Therefore, this authorization terminates on: (check all that apply):

Exact date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above has been explained to me and I understand it.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                Client/Parent/Guardian Signature                                               Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_             \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Chivic Healthcare Services Staff                                          Date