

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

The undersigned hereby authorizes the release of information from the health record of:

1. Client Name: _____ Last 4 #s of SSN: _____
 Date of Birth: _____ Phone Number: _____

2. **INFORMATION TO BE RELEASED FROM:** _____

INFORMATION TO BE RELEASED TO:
 Name: _____
 Address: _____

 Phone: _____

3. **INFORMATION AUTHORIZED FOR RELEASE (CHECK ALL THAT APPLY):**
 Psychiatric Evaluation Medications Medical/Physical history
 Discharge Summary Labs History/Psychosocial
 Psychiatrist Notes Nursing Notes Therapy Notes
 Other: _____

4. **RELEASE OF SPECIAL RECORDS**
 YOU MUST CHECK A RESPONSE TO EACH of the following statements in the event your record may contain such information:

- a. I DO I DO NOT authorize disclosure of records of alcohol or drug abuse treatment.
 b. I DO I DO NOT authorize disclosure of records of diagnosis of HIV or AIDS (including test results).

Alcohol and/or drug treatment records are protected under federal regulations governing the confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2, and the Health Insurance Portability and Accessibility Act, 45 CFR Parts 160 and 164. These rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law.

5. **PURPOSE FOR USE OR DISCLOSURE:** Personal Use Treatment Legal Other _____

6. **EXPIRATION:** Unless another date, event or condition is listed below, this authorization will expire one (1) year from the date it is signed. Other date, event, or condition:

7. *I understand RiverValley may not condition treatment or eligibility for care on my providing this authorization except if such care is (1) research related, or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party. If Client refuses to provide authorization under the aforementioned circumstances, RiverValley may refuse to provide care or treatment for these purposes.*

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 CFR Part 164) and the Privacy Act of 1974 (5 USC 552a) and the Client has the right to revoke this authorization at any time in writing and upon delivery to RiverValley, except to the extent that action has been taken in reliance of this authorization, or if applicable, during an insurance contestability period. I may request a copy of this form.

Client Signature _____
Date

Date

Signature of: Parent Guardian If other, specify relationship: _____

Witness Signature (required for release of hospital records) _____
Date