AUTHORIZATION OF RELEASE OF RECORDS OR INFORMATION

I, _____(name of client), DOB_____/_____/_____
hereby give permission to [program name] to release information as noted below:

❒ 14A-2 District Court

❒_____ Circuit Court

❒_____ Juvenile Court

❒_____

Address of Individual/Agency		
City	***State***	***Zip Code***
Area Code	***Phone Number***	

___ *My entire record;* ***(initial OR)***

Only the following information (initial** all that apply**):

☒ **Assessment** _____
☒ **Treatment Recommendations** _____
☒ **Expected length of treatment** _____
☒ **Attendance Records** _____
☒ **Progress Report of my treatment** _____

❑ Treatment Plan _____
❑ Name of new treatment provider _____
❑ **Other Evaluation** (Specify) _____
_____
❑ Diagnosis _____
❑ **Other** _____ (Specify):_____

Form in which the information should be released (initial** bold options**):

☒ **Verbal** ___
☒ **Written** ___
☐ Photography ___
☐ Video ___
☒ **Other**: **Electronic** I authorize staff to communicate by means of E-mail, fax and cordless or cellular telephones, where the use of these means is expedient or timely. ___

The purpose of this disclosure is to permit (initial** at least one**):

☒ **Continuity of care** ___
☐ Case management ___
☐ Reimbursement/processing of benefit claims ___
☐ Other: _____ ___

I understand that my records may contain protected information regarding diagnosis and/or treatment for :
HIV/AIDS virus, other sexually transmitted diseases, drug/alcohol diagnosis and/or treatment and/or psychiatric or mental health care and diagnosis.

Please **initial** the statements that apply:

I give consent to release my HIV (AIDS virus) diagnosis/treatment information _____.

I give consent to release my drug/alcohol/substance diagnosis/treatment information. _____.

I give consent to release my psychiatric diagnosis/treatment information _____.

~ O V E R ~

The timeframe within which this release of information is applicable is (**initial** one option):

___ a period not to exceed one year from the date this is signed

___ a time period from _____ to _____

___ an event (describe event:) **Completion of the** [program name] **and/or 90 days after Discharge from** [program name]

*If more than one box is checked, the authorization will expire by whichever time period/event is sooner.

I may revoke this consent at any time by contacting [program name] **except to the extent that action has been taken in reliance upon it.**

I understand I have the right to receive a copy of this authorization form.

_____ Signature of Client	_____ Date
_____ Signature of Witness/Notary	_____ Date