AUTHORIZATION TO RELEASE & EXCHANGE MENTAL HEALTH INFORMATION

COMMUNITY REACH CENTER

Consumer name:_____ **DOB:** _____ **ID#:** _____ **MRN** _____

Release To/From: The following organizations/ providers are hereby authorized to release, exchange, and share oral and written mental health information with each other, regarding the Consumer named above:

Community Reach Center

Release To/From:
Company/Organization/Person and Relationship:

_____

_____

Address:

(_____) _____ – _____ **Phone:**

(_____) _____ – _____ **Fax:**

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

- ☐ Alcohol and/or Drug Abuse Treatment
- ☐ Assessment
- ☐ Benefits Coordination/Acquisition
- ☐ Coordination/Continuity of Care
- ☐ Disability Determination
- ☐ Legal Purposes
- ☐ Other (Specify)_____
- ☐ Payment of Insurance Claims
- ☐ Referral
- ☐ Service Planning

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

- ☐ Alcohol and/or Drug Abuse Treatment
- ☐ Assessments/Intake
- ☐ Discharge Summaries
- ☐ Labs
- ☐ Legal Records and Information
- ☐ Medication History
- ☐ Monthly Reports
- ☐ Other (Specify)_____
- ☐ Progress Notes/Summary
- ☐ Psychiatric/Psychological Evaluations
- ☐ Treatment History
- ☐ Treatment/Service Plans

Please initial the below statements:

_____ I UNDERSTAND the information requested may include evaluation, diagnosis or treatment information regarding the following conditions: mental illness, alcohol or drug abuse, and 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 Co Cite and 42 CFR Part 2).

_____ 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 _____ (date), or, if left blank, **TWO YEARS** from the date of my signature (whichever event comes first). I release the Center from all liability for disclosing the requested information. I UNDERSTAND that treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization

NOTICE TO THE RECIPIENT OF THE INFORMATION

This information has been disclosed to you from records protected by federal confidentiality rules/HIPAA Privacy Regulations. This prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted in written consent of the person to whom it pertains 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. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

AUTHORIZATION: I understand that authorizing the disclosure of this information is voluntary. This Authorization may be used and re-used to obtain information learned and records prepared after the date this release was signed as long as this Authorization remains valid. I understand that when information is release, 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.

_____ _____

Consumer or PERSON AUTHORIZED TO SIGN FOR CONSUMER **Date**

_____

Print name if not the consumer and state how authorized to sign

_____ _____

WITNESS SIGNATURE and printed name **Date**