| Client ID#: | DOB: |
|---|---|
| Last 4 SSN: | |
| Client Name: | |

# Authorization for Release of (PHI) Protected Health Information

In accordance with Federal Regulations 42 CFR, Part 2, and HIPAA, I hereby authorize a Renewed Mind to ☐ **obtain** from / ☐ to **release** PHI to:

Name of Individual/Facility to **obtain**/**receive** PHI: ___________________________________

Complete Address: ________________________________________________________________

Phone: _____________________________________ Fax: _______________________________

**TYPE OF RECORDS**

| | |
|---|---|
| ☐ AOD-Substance Abuse | ☐ MH- Mental Health |

**INFORMATION TO BE OBTAINED/RELEASED**

| | | | |
|---|---|---|---|
| ☐ Discharge Summary | ☐ Diagnostic Assessment | ☐ Drug screens/results | ☐ Treatment Plan |
| ☐ Progress/Medical Notes | ☐ Psychiatric Evaluation | ☐ Aegis Lab Reports | ☐ Medication Information |
| ☐ Progress Reports /Recommendations | ☐ History and Physical Exams | ☐ Appointments/ Scheduling/ Attendance | ☐ Verbal and written communication |
| ☐Other: | | | |

**Specific date/time period for information selected above:** _____________________ to ______________________

*(Including psychiatric records related to emotional illness, and information regulated by Federal Public Law 930-282, confidentiality of alcohol and drug abuse clients. Also included are records documenting the diagnosis and/or treatment of AIDS/AC, HIV Positive and other related disease)*

**THE PURPOSE OF THIS DISCLOSURE IS:** (check one)

☐ COMPREHENSIVE TREATMENT ☐ FAMILY INVOLVEMENT ☐ AFTERCARE/FOLLOW-UP
☐ LEGAL ISSUES ☐ VERBAL COMMUNICATION
☐ OTHER (please specify): _______________________________________________________________

**CONFIDENTIALITY RULES:** This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you 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 42 CFR, Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

I understand that my payment for treatment services, my enrollment or eligibility for benefits cannot be conditional upon my giving authorization for disclosure of information for any other purpose.

I understand that the information disclosed is protected by law and may not be re-disclosed without my written authorization by law; however, I understand a Renewed Mind cannot control the recipient's use of the information.

This Authorization to Disclose/Obtain Confidential Information will automatically expire in 6 months (180 days) after the date of authorization unless **(CHECK)**:____________ **I expect to continue receiving treatment services beyond the 180 days and extend the authorization to a maximum of 1 year (365 days) or at termination, whichever is sooner.**

**Expiration Date is: ______________________. Condition, date or event of earlier/later expiration: ________________________.**

**NAME and SIGNATURE of staff facilitating this request:** _____________________________________________________

**SIGNATURE OF CLIENT:** ________________________________________________________ **Date:** ______________________

**SIGNATURE OF PARENT/GUARDIAN:** __________________________________________ **Date:** _______________________

**Description of Relationship:** __________________________________________________

*I understand that I and/or my parent/guardian/authorized representative, if appropriate, may revoke this authorization at any time, except to the extent that action has been taken in reliance on it, and that the revocation must be signed and dated by me, my parent/guardian/authorized representative. Upon revocation of consent, further release of information shall cease immediately.*

**I, ___________________________________ hereby revoke this consent for the release of the above information on: _________________.**

**Action to be taken:**

| | | | |
|---|---|---|---|
| ☐ Urgent | Date: | ☐ Scan only | Date: |
| ☐ Obtain from: | Date: | ☐ Release to: | Date: |