Nurturing abilities. Changing lives.

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AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Client (Last, First, Middle Initial)	Office Use Only MRN	Birth Date	
Street Address	City	State	Zip

CLIENT RELEASE AND SIGNATURE *(to include verbal, written, and/or electronic exchange of information)*

Release Information From *(Who has your records?)*	**Release Information To** *(Who needs your records?)*
Organization Address City/Sate/Zip Phone	Name/Organization Address City/Sate/Zip Phone

Information to be Released Service Dates From:_____To:_____

Service Programs

☐ Community Based Services (Day Habilitation, In-Home Supports, Residential/Independent Habilitation, Employment Programs)
☐ Behavioral Health/Autism Services ☐ Early Intervention ☐ Residential and Educational Services
☐ Mental Health Therapy ☐ Therapies (Speech, OT, PT)

The following Information is Requested

☐ Social History and/or Updates ☐ Behavior Program ☐ Progress Notes
☐ History & Physical Reports ☐ Immunizations Records ☐ Dental Reports
☐ Guardianship/Custody/Legal ☐ Discharge Orders/Summary ☐ Education Assessments/Testing
☐ Psychological Reports ☐ Psychiatric Evaluation Notes ☐ Quarterly Reports
☐ Evaluations
☐ Specific Consult Report _____*(Be specific i.e. date, physician, etc.)*
☐ Other _____*(Be specific)*

ALL RECORDS PERTAINING TO PSYCHIATRIC/MENTAL HEALTH, ALCOHOL AND/OR DRUG DEPENDENCY, AND/OR HIV/HIV RELATED ILLNESS WILL NOT BE RELEASED UNLESS SPECIFICALLY AUTHORIZED BELOW IN WRITING.
I specifically authorize the release of the following records:

☐ Chemical Dependency_____ ☐ Psychiatric/Mental Health_____ ☐ HIV/AIDS-related Content
(initials) *(initials)* *(initials)*

The Information Identified Above will be Used For *(check each purpose)*

☐ Coordination of services, continuity of care
☐ Personal
☐ Insurance Billing
☐ Legal
☐ Other _____*(please list/be specific)*

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage, I authorize the facility/provider to disclose medical information to the party identified in the "Release Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits. **This authorization expires one year from the date of my signature unless I specify a different event, purpose or alternative expiration date here** _____

Signature of Client		Date
Signature of Parent/Guardian or Custodian (if needed)	**Relationship to Client (REQUIRED)**	Date