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|--------------|------|
| 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

| | |
|--|--|
| <input type="checkbox"/> AOD-Substance Abuse | <input type="checkbox"/> MH- Mental Health |
|--|--|

INFORMATION TO BE OBTAINED/RELEASED

| | | | |
|--|---|---|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Diagnostic Assessment | <input type="checkbox"/> Drug screens/results | <input type="checkbox"/> Treatment Plan |
| <input type="checkbox"/> Progress/Medical Notes | <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Aegis Lab Reports | <input type="checkbox"/> Medication Information |
| <input type="checkbox"/> Progress Reports /Recommendations | <input type="checkbox"/> History and Physical Exams | <input type="checkbox"/> Appointments/ Scheduling/ Attendance | <input type="checkbox"/> Verbal and written communication |
| <input type="checkbox"/> 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:

| | | | |
|---------------------------------------|-------------|--------------------------------------|-------------|
| <input type="checkbox"/> Urgent | Date: _____ | <input type="checkbox"/> Scan only | Date: _____ |
| <input type="checkbox"/> Obtain from: | Date: _____ | <input type="checkbox"/> Release to: | Date: _____ |