**AUTHORIZATION TO OBTAIN, DISCLOSE AND EXCHANGE PROTECTED HEALTH INFORMATION**

**AUTHORIZATION**-The undersigned hereby authorizes the name/agency listed to Obtain From, Disclose To, and Exchange

with, protected health information either orally or in writing to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

NAME/AGENCY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**A.** Any and all information, EXCEPT substance abuse (drugs and alcohol), mental health, and AIDS-related

information, must be specifically authorized in Section E to be disclosed: OR ONLY the following information

(check only if applicable):

**B.** Check one(s) that applies:

\_\_\_Summaries and notes of participation in treatment. \_\_\_Evaluations and Recommendations

\_\_\_Psychological and psychiatric testing & evaluation results \_\_\_Treatment Plan, Progress & Discharge reports

\_\_\_Information relating to medical history \_\_\_Information relating to social history

Other information\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**C. PURPOSE-**The purpose for this disclosure is to facilitate effective treatment service coordination. A photocopy or

exact reproduction of this Authorization shall have the same effect as the original.

**D. SPECIFIC AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION PROTECTED BY STATE AND FEDERAL**

**LAW**

I acknowledge that information to be disclosed may include material that is protected by Federal and/or State law

applicable to substance abuse, mental health and AIDS.

\_\_\_Substance abuse (drug or alcohol) information

\_\_\_Mental Health information

\_\_\_AIDS-related information

**E.** Furthermore, I SPECIFICALLY AUTHORIZE disclosure of protected health information to all persons referred to in

the authorization. The undersigned has a right to inspect the disclosed information and information being

obtained from, disclosed to, and/or exchanged with at any time. This authorization shall be in effect for 12 months

(or\_\_\_\_\_months) from the date it is signed, or if applicable, until the date of the final disposition of the conditional

release or other court action in connection with which this consent is given {42 CFR 2.35 J(c)}. Also, the

undersigned understands he/she may revoke this authorization at any time, except to the extent that action has

already been taken in reliance upon, and by giving written notice to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**F.** I hereby authorize disclosure of protected health information as indicated above and acknowledge that I may

receive a copy of this document upon request.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date of Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Signature (if client is a minor) Date of Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Date of Signature

Revised 04-16-2012