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REQUEST/AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS & INFORMATION

Source of information

Person or facility: _____

Address: _____

Phone: _____

A. Identifying information about me/the patient

Name: _____

Address: _____

Phone: _____ Birthdate: _____ Social Security #: _____

B. I hereby authorize the source named above to send, as promptly as possible, the records listed below marked by a check in the boxes below. (The items not to be released have a line drawn through them. Page numbers are indicated where appropriate.)

☐ Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness or drug or alcohol abuse:
Date(s) of inpatient admission: _____ Date(s) of discharge: _____
Start of outpatient treatment: _____ End of treatment: _____
Clinic/patient number: _____
Other identifying information about the service(s) rendered:
_____

☐ Psychological evaluation(s) or testing records, and behavioral observations or checklists completed by any staff member or by the patient.

☐ Psychiatric evaluations, reports, or treatment notes and summaries. Treatment plans, recovery plans, aftercare plans.

☐ Admission and discharge summaries.

☐ Social histories, assessments with diagnoses, recommendations, and all similar documents.

☐ Information about how the patient's condition affects or has affected his or her ability to complete tasks, activities of daily living, or ability to work.

☐ Workshop reports and other vocational evaluations and reports. Billing records.

☐ Academic or educational records. Report of teachers' observations.

☐ Achievement and other test results.

☐ A letter containing dates of treatment(s) and a summary of progress.

☐ HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: ☐ **Do not release.**

☐ Other: _____

C. I authorize the source named above to speak by telephone with the therapist identified in part K about the reasons for my/the patient's referral, any relevant history or diagnoses, and other similar information that can assist with my/the patient's receiving treatment or being evaluated or referred elsewhere.

D. I understand that no services will be denied me/the patient solely because I refuse to consent to this release of information, and that I am not in any way obligated to release these records. I do release them because I believe that they are necessary to assist in the development of the best possible treatment plan for me/the patient. The information disclosed may be used in connection with my/the patient's treatment.

E. This request/authorization to release confidential information is being made in compliance with the terms of the Privacy Act of 1974 (Public Law 93-579) and the Freedom of Information Act of 1974 (Public Law 93-502); and pursuant to Federal Rule of Evidence 1158 (Inspection and Copying of Records upon Patient's Written Authorization). This form is to serve as both a general authorization, and a special authorization to release

information under the Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255), the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974 (Public Law 93-282), the Veterans Omnibus Health Care Act of 1976 (Public Law 94-581), and the Veterans Benefit and Services Act of 1988 (Public Law 100-322). It is also in compliance with 42 C.F.R. Part 2 (Public Law 93-282), which prohibits further disclosure without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

F. In consideration of this consent, I hereby release the source of the records from any and all liability arising there from.

G. This request/authorization is valid during the pendency of any claim or demand made by or in behalf of me/the patient, and arising out of an accident, injury, or occurrence to me/the patient.

H. I understand that I may void this request/authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive. **If I do not void this request/authorization, it will automatically expire in 120 days from the date I signed it.**

I. I agree that a photocopy of this form is acceptable, but it must be individually signed by me, the releaser, and a witness if necessary.

J. I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request.

K. Signatures

_____	_____	_____
Client Signature	Client Name (Print)	Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

_____	_____	_____
Witness Signature	Witness Name (Print)	Date

I, a mental health professional, have discussed the issues above with the patient. My observations of behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____	_____	_____
Professional's Signature	Professional's Name (Print)	Date

☐ Copy for source of records

☐ Copy for recipient of records