

AUTHORIZATION TO DISCLOSE CLIENT INFORMATION

Name of Client: _____ Date of Birth: _____

The following programs are authorized to: disclose, receive, or exchange information as noted below.

Program Authorized to Make Disclosure

Authorized Individual/Organization to Whom Disclosure is Made

Purpose of Disclosure: to coordinate treatment, to gather assessment information for treatment planning, to gather information for ongoing treatment, other purposes [specify]

Type of Information to be Disclosed: progress notes, diagnostic assessment information, progress in treatment, lab results, urine testing, attendance, HIV/AIDS testing or status, pregnancy testing, prenatal care, diagnosis, information on mental illness and/or treatment, other information [specify]

Amount of Information to be Disclosed: information covering the previous three months, information covering the most recent admission, other amount of information [specify]

Signature and Date of Client or Other Person Authorized to Permit Disclosure

Signature and Date of Staff or Witness

Revocation: This authorization is subject to written revocation at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it.

I hereby revoke consent _____
Clients Signature and Date

Signature and Date of Person Witnessing Revocation

This authorization expires [specify event, date and/or condition] _____

Prohibition Against Re-Disclosure: 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 C.F.R., 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