GENERAL AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Client Name:_________________________________ DOB:______________ Record #:_________________

I authorize ______________________, to release and/or receive the following protected health information (in written and/or oral form) regarding:

- ☐ Initial Meeting and Recommendations
- ☐ Diagnosis and/or Assessment
- ☐ Summary of Services Provided
- ☐ Summary of Client Participation/Progress
- ☐ Dates of Service Delivery
- ☐ Coordination of Care
- ☐ Other:______________________________

I authorize such protected health information to be disclosed to/received from the following people or entities:

I understand that my protected health information will be used for:

- ☐ Assisting with evaluation and service delivery
- ☐ Coordinating services between _________________ /person named above
- ☐ Participation in the monthly Multi-Disciplinary Team meetings including law enforcement, mental health, department of social services, district attorney's office, and juvenile justice department from multiple districts
- ☐ Transferring information regarding previous Services rendered
- ☐ Other:______________________________

I understand that health information to be release includes diagnoses, medications and recommendations. By signing this form, I am specifically authorizing the release of information relating to:

- ☐ Mental Health treatment
- ☐ Medications
- ☐ Diagnoses
- ☐ Substance Abuse Treatment

I understand that this authorization will automatically expire on _________________________.
(Not to exceed one year.)

I understand that:

(a) I may refuse to sign this authorization. ________________ may not condition treatment upon the signing of this Authorization unless such treatment is solely for the purpose of creating protected health information for disclosure to a third party.
(b) I may revoke this Authorization at any time, except to the extent ________________ has already taken action in reliance on this Authorization. My revocation of this Authorization must be submitted in writing to the Provider at the address indicated above.
(c) I am voluntarily signing this Authorization and will receive a copy if requested.
(d) The protected health information authorized to be released pursuant to this Authorization may be re-disclosed by the recipient and may no longer be protected under the federal privacy laws.

Client Signature:____ Date:_____________________
(Client or Legal Guardian)

Relationship to Client:____