## AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Client Name:_____ DOB:_____ Client #:_____

Clinician: _____

I, _____, hereby authorize
Client/guardian

| **To RECEIVE the following information:** | **To DISCLOSE the following information:** |
|---|---|
| *(Please check the appropriate box(es))* | *(Please check the appropriate box(es))* |
| ρ Any and all information relating to my care and treatment by the above-named provider. | ρ Any and all information relating to my care and treatment by the above-named provider. |
| ρ **Only** the following information:<br>ρ Demographics<br>ρ Assessment<br>ρ Progress Notes<br>ρ Treatment Plan<br>ρ Discharge Summary<br>ρ Other (please specify)<br>_____<br>_____ | ρ **Only** the following information:<br>ρ Demographics<br>ρ Assessment<br>ρ Progress Notes<br>ρ Treatment Plan<br>ρ Discharge Summary<br>ρ Other (please specify)<br>_____<br>_____ |

**Information to be RECEIVED FROM/DISCLOSED TO:**

Name: _____ Company: _____

Address: _____

**The purpose of this release is:**

ρ Coordination of services ρ Obtain records ρ Determine eligibility for services
ρ Legal purposes ρ ISP/ITP planning
ρ Other (please specify) _____

If I have been diagnosed or treated for any of the following, I understand that Island Institute for Trauma Recovery, LLC needs my specific consent to disclose related information. In no event may any such information, if applicable, be disclosed without my specific consent. I authorize the above-named provider to make subsequent disclosures to the same recipient pursuant to this authorization. **Unless earlier revoked, this consent expires in 90 days or on the following date not to exceed one (1) year.**

***Specified Date:*** _____

**I DO *DO NOT*** authorize disclosure of information which refers to treatment of diagnosis of drug or alcohol abuse (Federal drug & alcohol regulations, 42 CFR 2.31). Such information may not be disclosed by the recipient without my specific written consent.

**I DO *DO NOT*** authorize release of any information that may relate to diagnosis/treatment for HIV, ARC, or AIDS.

**I DO *DO NOT*** authorize release of any information that may relate to mental health treatment.

I understand that the above information may be covered by the rules of the Department of Health and Human Services (the "Rights of Recipients of Mental Health Services" or the "Rights of Recipients of Mental Health Services Who Are Children In Need of Treatment").

I understand that I may refuse to release some or all of the information in the provider's records, but that such refusal may result in improper diagnosis or treatment, denial of coverage or denial of a claim for health benefits or insurance, or other adverse consequences. The provider will not deny treatment on signing this authorization, unless the health care is solely for purpose of creating the information listed above for the person listed above.

Client #:_____

Per company policy, Island Institute for Trauma Recovery, LLC. will NOT release information created by other practitioners or facilities. Statements added to records by clients and/or guardians will not be released without written consent. I understand that if the above listed information is disclosed, it is possible that it may be re-disclosed by the recipient, or that it may no longer be subject to confidentiality protections.

I waive my right to review this information prior to its disclosure: Yes No

I authorize the provider to send/receive these records by fax: Yes No FAX#_____

I acknowledge that I have been offered a copy of this authorization: Yes No

I understand that I may cross out any words on this form with which I disagree, and that I may revoke this authorization at any time.

I understand the matters discussed on this form. I release the Provider, its employees, officers, and medical staff, and business associates from any legal responsibility, or liability for the disclosures of the above information to the extent indicated and authorized herein.

**Signatures:**

| | | | |
|---|---|---|---|
| Client | | Date | |
| Authorized Representative | | Date | |
| Relationship to Client | | | |
| Witness | | | |

## ** * * Request to Revoke Statement below. * * **

## * * * Request to Revoke * * *

I understand that I may revoke this authorization at any time by giving written or verbal notice to Island Institute for Trauma Recovery, LLC using this form or any other written statement. This will not affect information released prior to receiving my request to revoke. I understand that revoking this authorization may be the basis for denial of health benefits or other insurance coverage benefits.

**My signature below officially revokes this authorization:**

| | | | |
|---|---|---|---|
| Client | | Date Revoked | |
| Authorized Representative | | Date Revoked | |
| Relationship to Client | | | |
| Witness | | | |