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| Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Authorize: **Optimum Potential Community Services** to \_\_ Release **\_\_** Obtain –**\_\_ -**Exchange with **\_\_ -** information contained in my medical records:  |
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| Name of Individual (s)/agency (s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **SPECIFIC TYPE OF INFORMATION TO BE DISCLOSED** |
| **Please check requested information below** | **Please check requested information below** |
|  | Psychiatric Eval / Treatment |  | SSA/DCF |
|  | Psychological Evaluation |  | Academic classroom/behavior |
|  | Testing Information |  | Legal information |
|  | Court order |  | Medication information |
|  | Diagnosis |  | Discharge Summary |
|  | Treatment Progress |  | Alcohol/substance abuse treatment history |
|  | Progress Note |  | Medical Treatment |
|  | Telemedicine  |  | Other:  |
|  | Bio-psychosocial Assessment |  | Other:  |
| PURPOSE OF DISCLOSURE |
| **Please check requested information below** | **Please check requested information below** |
|  | Care/Treatment, Ongoing |  | Treatment progress |
|  | Treatment Planning |  | To Follow Up Physician Referral |
|  | To Bill Insurance for |  | To Aid in Child Custody Case |
|  | Payment of services |  | Mental Health Counseling |
|  | Telemedicine  |  | Other specify:  |
|  | TCM Services  |  | Other specify: |
| I understand that my records (including any alcohol, drug abuse, or mental status information) are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except that action has been taken in reliance on it (e.g. probation, parole, etc.) and that in any event this consent expires automatically as described below. Prohibition on re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42 C.F.R. Part 2) prohibits you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500 in the case of a first offense and not more than $5,000 in the case of each subsequent offense. **Drug abuse Office and Treatment Act of 1972(21 USC 1175) Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (42 &SC4582), Federal Register, Vol. 40,l No. 127, Tuesday, July 1, 1975.** |
| This **Authorization for the Release of Confidential Information** shall become effective on the date of execution of my signature hereinafter, and this **Authorization**, which grants specific authority for the release of protected health information by Optimum Potential Community Services, shall remain valid until **(\_\_\_\_\_\_**) upon which this **Authorization** shall automatically expire. I retain the right to revoke this **Authorization** at any time by providing a written notice to Optimum Potential Community Services, but I understand and agree that my consent to release information shall remain in effect until the date the revocation is date stamped in by the Medical Records Department, and any documents released previous to that date are considered to be authorized and approved by me |
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Client/Guardian signature: Date: |
| Staff/Contractor signature: Date:  |