

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Use this form if the Client requests ongoing release OR if request is from someone other than the client or their legal representative

Client Name: _____ D.O.B.: ___/___/___ Client #: _____

I authorize South Central Human Relations Center to **send** **request** the private data specified below to/from:
 (A fee may be charged)

Name/Entity/Category: Name of School

Address _____ City _____ State _____ Zip _____

Email: _____ Encrypted: I understand the risk and request unencrypted:

Fax: _____ Phone: _____ HIE/PHR _____

Information to be Released: Ongoing or Date from _____ to _____ or specific visit date: _____

check what you want released

- Assessment/Evaluation Testing Results PSI/Police Report Labs/Meds/Allergies
- Progress Notes Verbal Information Admission/Discharge/Transfer Alerts
- Letter(s) Healthcare Provider Portal Other (specify) attendance information
- Continuity of Care Doc (CCD)

You must specifically request the following for it to be released:

- Chemical Dependency Program
- Psychotherapy Notes (conversational analysis) No other items can be checked when requesting this item

Reason: Assessment and Treatment Planning Continuity of Care
 Other (specify, e.g. legal, appeal SS Disability) attendance information

Valid for: One year or for this specified period: _____

This authorization **does** **does not** extend to information placed in my record after the date I sign this form.

- I understand that my records to be released may contain information regarding substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS-related information.
- I understand that I have the right to revoke this authorization by signing "I revoke..." below and returning to SCHRC. If South Central Human Relations Center has already released information based on this consent, we cannot retrieve what has already been released.
- I recognize that the protected health information used or disclosed according to this authorization may be re-disclosed by the recipient and SCHRC can no longer protect it.
- I understand that I may refuse to sign this consent, if I so desire, and that SCHRC may not refuse treatment if I do not sign, but refusal may have consequences that have been explained to me.

Signature:

Indicate if you are: Client, Parent, or Personal Representative (Provide legal proof if representative not parent) _____ Date _____

Type of identity verification _____

I **revoke** this authorization: _____ Signed _____ Date _____