AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

CLIENT INFORMATION

NAME		DATE OF BIRTH
ADDRESS		
CITY	STATE	ZIP
OTHER NAME(S) USED		

HEALTH INFORMATION RELEASE

☐ I authorize Northern Psychiatric Associates to **RECEIVE** information **FROM**

☐ I authorize Northern Psychiatric Associates to **RELEASE** information **TO**

THIS IS TO INCLUDE VERBAL COMMUNICATION

NAME		FACILITY NAME
ADDRESS		
CITY	STATE	ZIP
FAX		PHONE

PURPOSE OF DISCLOSURE

☐ Continuity of care ☐ Client Request ☐ Legal/Attorney ☐ Other- ________

HEALTH INFORMATION TO BE RELEASED

☐ **Entire Health Record** (includes all records listed below)

OR

☐ **Part of Health Record**

☐ History and Physical ☐ Consultations ☐ Laboratory Results ☐ Emergency Department Records

☐ Progress in Treatment ☐ Discharge Summary ☐ Psychiatric Diagnostic Evaluation

☐ Alcohol and Chemical Dependency Evaluation Findings and Reccomendations

☐ Other ________

AUTHORIZATION

This authorization will expire no more than 12 months from the date I sign this form unless otherwise specifically permitted by law

I understand that

- I may revoke this authorization at any time by notifying, in writing, Northern Psychiatric Associates.
- Revoking this authorization does not apply to information that has already been disclosed under this authorization.
- I have the right to inspect or obtain a copy of the health information disclosed.
- If the disclosed information goes to a health care provider or a health plan covered by federal privacy laws it will be protected by federal privacy laws. Information that goes to other persons/entities may not be protected by state or federal privacy laws and may be re-disclosed.
- Northern Psychiatric Associates cannot prevent the re-disclosure of protected health information releases as a result of this request and therefore, Northern Psychiatric Associates is released from any and all liability resulting from re-disclosure.
- If this release involves the disclosure of information concerning a client who is in alcohol or drug abuse treatment, this information has been disclosed from records protected by federal confidentiality rule, 42 CFR, Part 2. The federal rule prohibits 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 as otherwise permitted by 42 CFR, 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 the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I do not have to sign this form. Treatment may still be provided to me if I do not sign this form

________________________________ ________________________________

Client/ Guardian Print (if client under 18) Relationship to Client

________________________________ ________________________________

Client/ Guardian Signature (if client under 18) Date