AUTHORIZATION FOR THE RELEASE / EXCHANGE OF INFORMATION

- **I understand that my records may be protected under the Federal Confidentiality Regulations (42 CFR Part 2) and, if so, cannot be disclosed without my written consent unless otherwise provided for in the regulations and/or under state specific provisions.**
- **I understand that my records may contain information regarding my mental health, substance use or dependency, sexuality, suicidality, and may contain confidential HIV (AIDS) related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.**

Patient Name	Date of Birth	SS# or Chart Number	
Street Address	City	State	Zip Code

I authorize _____ to (please check and initial):
name of individual, company, or organization

☐____ ***Exchange with*** ☐____ ***Release to*** ☐____ ***Obtain from*** the party I have indicated below:

Name	
Relationship	
Address	
City/State/Zip	
Phone Number	

I authorize the release/exchange of the following medical records and information (check all applicable):

- ☐ All materials in records
- ☐ Medical history
- ☐ Psychosocial history
- ☐ Assessment and diagnosis
- ☐ Progress Notes
- ☐ Treatment Plans
- ☐ Substance use assessment and treatment
- ☐ Medication and treatment records
- ☐ Summary of psychological testing
- ☐ Discharge summary
- ☐ Attendance only
- ☐ Only in an emergency
- ☐ Other: _____

This information is required for (check one or more option(s)):

- ☐ Summary of previous treatment
- ☐ Continuity of care
- ☐ To keep patient's parent(s) aware of treatment
- ☐ Insurance / managed care review (for justification of charges, quality of care, treatment progress, and/or medical necessity).
- ☐ Other _____

I understand that the information or records listed above will not be used for any purpose other than the intended use. The re-release of this information to parties other than those named above is prohibited. Furthermore, the records requested and all copies of the information will be destroyed or returned before or immediately after the date listed below.

I understand that I may revoke this authorization at any time, unless action has already been taken on it, by giving written notice to the parties below.

This authorization automatically expires, unless otherwise provided by state law, on (specific date): _____
recommend date 6 months to no more than 1 year from date of signature below

Signature of Patient/Legal Guardian _____ Relationship to Patient (if applicable) _____ Date _____

Signature of Minor Patient _____ Date _____

Signature of Witness / Requestor of Information _____ Date _____

A copy of this form has been requested and received (initialed by patient): _____ **Yes** _____ **No**