Authorization for Disclosure of Protected Health Information

Client Information:

Name ______________________ Address ______________________ Birthdate __________

Family information (if applicable):

Name	Birthdate	Name	Birthdate

AUTHORIZATION:

I authorize The Village Family Service Center to
☐**release to:**
☐**obtain from:**
☐**mutually exchange with:**

Name and/or Organization: ______________________

Address: ______________________

Specific information: ☐**Written** ☐**Verbal**

☐Diagnosis/Treatment	Medical information:	☐Court Order
☐Assessment/progress reports	☐Current medical condition	☐Parole/Probation reports
☐Coordination of care information	☐Medical history	☐Data Reporting
☐Opening/closing summaries	☐Admit/Discharge info	☐Abuse/Neglect reports
☐School/education information	☐Testing info__________	☐Police report on __________
☐Psych. testing & assessment	☐HIV/AIDS/STD info	☐Other__________
☐C.D. Assessment	☐__________	

This information is requested for the following PURPOSE:

☐Assessment/Diagnosis	☐Legal Purposes	☐Insurances/Billing	☐ Custody Evaluation
☐Treatment/Service	☐Aftercare treatment	☐Family Involvement	☐Other__________

Specific Authorization (please initial to authorize disclosure of this information)

________Drug/alcohol specific — My records may contain information regarding diagnosis and/or treatment for drug or alcohol abuse. I give my authorization for these records to be released. This portion of my record is protected by the Federal Confidentiality Rule (42 CFR, Part 2) and may not be further disclosed without my written consent.

Your rights regarding this authorization:

1) This authorization is voluntary and you may revoke it **at any time upon written request**. Any information released prior to your written revocation of this authorization will not be a breach of confidentiality. You understand that your services and payment for your services will not be affected if you do not sign this form.
2) This authorization will remain effective until the following date, event or condition:
   ☐requested materials are disclosed/received
   ☐case closure
   ☐other______________________
3) A photocopy of this authorization has the same effect as the original and, when necessary, may be faxed.
4) If the individual or organization that receives this information is not covered by the federal privacy regulations, the information disclosed will no longer be protected by the federal rule, and cannot be safeguarded against re-disclosure.
5) In MN, individuals 16 years of age or older, and in ND 18 years of age or older must sign authorization for the disclosure of their protected health information.

______________________ __________
Signature of Client *Date*

______________________ __________
Signature of Client *Date*

______________________ __________
Signature of Client *Date*

______________________ __________
Signature of Client *Date*

______________________ __________
Signature of personal representative (if client is unable to sign) *Date*

____
Relationship to Client/Legal authority (if signing for client) (parent, custodian, legal guardian, power of attorney, etc.)

______________________ __________
Signature of Witness *Date*

Please return to:______________________

at______________________