

# FORENSIC AND MENTAL HEALTH SERVICES, LLC

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## Authorization to Release Confidential Information

Client Name: \_\_\_\_\_ Chart #: \_\_\_\_\_

Last First

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Parent/Guardian (if applicable): \_\_\_\_\_  
Last First

I hereby authorize \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Name and title of person/organization Phone

Address

Address Continued (\_\_\_\_) \_\_\_\_\_  
Fax

- To release information to Dr. Magazine
- To receive information from Dr. Magazine

### Information to be released/received:

- Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness or drug or alcohol abuse:  
Date(s) of inpatient admission: \_\_\_\_\_ Date(s) of outpatient treatment: \_\_\_\_\_  
Other identifying information about the service(s) rendered: \_\_\_\_\_
- Psychological evaluation(s) or testing records, and behavioral observations or checklists completed by any staff member or by the patient.
- Psychiatric evaluations, reports, or treatment notes and summaries.
- Social histories, assessments with diagnoses, prognoses, recommendations, and all similar documents.
- Information about how the patient's condition affects or has affected his or her ability to complete tasks, activities of daily living, or ability to work.
- A letter containing dates of treatment(s) and a summary of progress.
- HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here:  *Do not release.*
- Workshop reports and other vocational evaluations and reports.
- Treatment plans, recovery plans, aftercare plans.
- Billing records.
- Report of teachers' observations.
- Other: \_\_\_\_\_
- Admission and discharge summaries.
- Academic or educational records.
- Achievement and other tests' results.

The purpose of this disclosure is to assist in:

Diagnosis/Treatment/Assessment       Discharge Planning       Other: \_\_\_\_\_

- As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records.
- I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization.
- I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization.
- A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records.
- I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity. If this information is being disclosed from records protected by the Federal substance abuse confidentiality rules (42 CFR part 2), the Federal rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by your written authorization or as otherwise permitted by 42 CFR part 2. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

This authorization expires  one year from date signed       Upon termination of services  
 Other date or event: \_\_\_\_\_

This information may be disclosed effective:  Immediately       Date: \_\_\_\_\_

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

\_\_\_\_\_  
Signature of Individual or Individual's  
Legal Representative if Individual is  
Unable to Sign

\_\_\_\_\_  
Date

Relationship or Authority of Legal Representative \_\_\_\_\_  
(if applicable)

\_\_\_\_\_  
Witness (Printed and signed name)

\_\_\_\_\_  
Date

Copy for patient or parent/guardian       Copy for provider/therapist       Copy for source of records