Consent for the Release of Confidential Information

Patient Name:_____ Date of Birth: _____

I hereby authorize and direct _____ to release and/or request protected health information (PHI) for the above named patient.

Name/Agency:_____

Address:_____

Phone:_____

E-mail:_____

For the following purpose(s):

__ Treatment Coordination and Continuing Care
__ Legal Action/Proceedings
__ Case Review
__ Eligibility/Benefits
__ Personal Request of Client
__ Other: _____
_____

Note: The purpose of the disclosure authorized herein is to communicate with the authorized person and/or organization above on an ongoing basis during the client's participation in treatment, for compliance with a court order, or to assist in the client's defense.

By signing this form, I consent to the release of my confidential health records. I understand that my records are protected under State and Federal regulations pertaining to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Privacy Rule is located at 45 CFR Part 160 and Subparts A and E of Part 164. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires on _____ or automatically within one year from today's date.

By signing below, I acknowledge that I have read, understood, and agree to the items contained in this document.

_____
Patient Signature Date

_____
Signature of Legal Guardian/Representative Date