Authorization for Release and Request of Health Information

Name: _____ Date of Birth: _____

Information regarding a clients' substance use disorder is to be held confidential between a client and Providence Recovery staff. Often, we receive phone calls from family/caregivers regarding a clients' condition and progress. In addition, other agencies you interact with may desire information to better help and create programming for you. I however understand my right as a client to have all information concerning my substance use disorder and related behavioral health and physical health conditions to be held strictly confidential unless I allow for information exchange.

I hereby authorize Providence Recovery Services to release or request the following personal information about me:

Request Verbal/Written Information from:

Organization: _____ Person: _____
Address: _____ Phone Number: _____
Fax Number: _____

Release Verbal/Written Information to:

Organization: _____ Person: _____
Address: _____ Phone Number: _____
Fax Number: _____

Specific information to be used/disclosed/requested includes: (Please initial only those that apply)

_____ Assessment, diagnosis
_____ Medication assessment, records
_____ Update and/or discharge summaries
_____ Social History, background
_____ All substance use disorder information
_____ Other (specify)_____
_____ Legal Information
_____ HIV/AIDS/Hepatitis Information
_____ Medical/lab information
_____ Payment and balance related information
_____ Evaluations or testing

Information will be released for the purpose of: (Please initial only those that apply)

_____ Continuity of care
_____ Service Planning
_____ At request of client
_____ Reports to courts or other agencies
_____ Treatment, payment or healthcare operations
_____ Additional evaluation or treatment
_____ Coordination of Care
_____ Obtaining basic needs/benefits for client
_____ Other _____

Note about this authorization:

This authorization can be terminated at any time in writing and is valid for two years. Your ability to receive treatment from Providence Recovery Services is not contingent upon your signing this authorization unless a court or other legal entity has required your treatment. Providence Recovery Services cannot guarantee that the identified person/organization will not re-release the disclosed information to another party as the recipient of this information may or may not be subject to federal laws protecting health/substance use information.

Signed:_____ _____ _____
(Client) Date Witness

I revoke my authorization for this use and disclosure of my health /substance use information, effective immediately.

Signed:_____ _____ _____
(Client) Date Witness