Clinical Records

AUTHORIZATION TO PROVIDE VERBAL & RELEASE WRITTEN PROTECTED HEALTH INFORMATION

Full name

Date of birth

include AKA, maiden, etc

I authorize that information may be exchanged between the following and Summit View Counseling:

Name / Facility

Address

Phone

Fax

Relationship to client

Purpose of the disclosure

The following information:

- [ ] Diagnosis
- [ ] Drug/Alcohol treatment
- [ ] Clinical Progress Notes
- [ ] Psychiatric evaluation/notes
- [ ] Discharge summary
- [ ] Psychological notes

I understand that information disclosed pursuant to this authorization may include information relating to sexually transmitted disease, HIV/AIDS,treatment for alcohol and drug abuse (protected by Federal Law, 42 CFR, Part 2), and psychological or psychiatric conditions unless restricted as follows:

Once information is disclosed pursuant to this signed authorization, I understand that the general federal privacy law (45 C.F.R., Parts 160 and 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it.
I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. In order to revoke this authorization with respect to information other than drug and alcohol treatment program records, I understand that I must provide written notice to Summit View Counseling (SVC). If not revoked earlier, this release/authorization will expire one year from the most recent date signed. I hereby release the above parties from liability that may result from furnishing this information. A copy of this release/authorization may be utilized with the same effectiveness as an original.
I understand that I may refuse to sign this authorization, and this will not affect my ability to receive treatment at SVC.
SVC does not recommend e-mail as a means of communication with Center employees. There is some risk that any protected health information that may be contained in such e-mail may be disclosed to, or intercepted by, unauthorized third parties. By signing this form you are acknowledging that email is not secure and you are releasing SVC from any liability relating to unauthorized disclosure of PHI contained in e-mail correspondence.

CHARGES FOR COPIES AND REPORTS MAY APPLY

Signature of Client, Parent/Guardian (for client under 14 years of age), or Authorized Representative, including your authority to act for client

Date signed

valid 1 year

Signature and Date to Extend Request

NOTICE TO RECIPIENTS OF DRUG AND ALCOHOL TREATMENT PROGRAM INFORMATION:
This information has been disclosed to you from records protected by Federal Law (42 CFR, Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other

information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.