



AUTHORIZATION FOR RELEASE OF INFORMATION
HIPAA COMPLIANT RELEASE

2017

Patient's Name: _____ DOB: _____

Release of Information **FROM:** _____

TO: _____

I hereby authorize and request the exchange of information between Little Rivers Health Care and the above named individual/organization. The following information is requested to be shared:

- | | | |
|--|---|--|
| <input type="checkbox"/> All | <input type="checkbox"/> Only those items which are pertinent to this referral | |
| <input type="checkbox"/> Office Notes | <input type="checkbox"/> Intake Assessment | <input type="checkbox"/> Test Results |
| <input type="checkbox"/> Psych/Social/Emotional Evaluation | <input type="checkbox"/> Medications | <input type="checkbox"/> Treatment Plan |
| <input type="checkbox"/> Immunizations | <input type="checkbox"/> Summaries | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Counselor Reports | <input type="checkbox"/> Teacher Reports | |

Date range of records to release (check one): Only documents from _____ to _____ All dates

Reason for Request _____

Form of Disclosure (check all allowed) Written Verbal Electronic

•Release of confidential information is subject to State and Federal Laws. By signing this release, I acknowledge my permission to release the above information to and/or from the individual or agency I have named which may include drug and alcohol abuse information.

Note: Federal regulations govern the confidentiality of alcohol and drug dependent persons (42CFR Par 2). Federal Law prohibits the disclosure of (1) psychotherapy notes, (2) information compiled in reasonable anticipation, or for the use in civil, criminal, or administration action or proceedings.

•I understand I may revoke this authorization at any time by notifying LITTLE RIVERS HEALTH CARE in writing, except to the extent that: a) action has been taken in reliance on this authorization; or, b) if this authorization is obtained as a condition or obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

•I understand I have a right to request and receive a **Notice of Privacy Practices** for LITTLE RIVERS HEALTH CARE, INC.

•All releases expire one year from the date signed unless otherwise indicated. Optional expiration date: _____

•I hereby authorized the following; (please initial if applicable)

_____ Disclosure of the results of HIV antibody blood testing and/or information concerning AIDS (Acquired Immune Deficiency Syndrome).

Signature of Patient or Patient's Representative

Printed Name

Relationship

Witness Signature/Printed Name

Date:

Prohibition of Re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.