THE REMEDY
A BETTER WAY FORWARD

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Psychiatric /Substance Use Disorder Release of Information

Client Authorization for Release of Protected Health Information
42 CFR Part 2 Prohibits unauthorized disclosure of these records.

Client Last Name_____ Client First Name_____ DOB_____

1. I authorize the disclosure, exchange and use of my protected health information ("Information") between The Remedy and the organization/person listed below:

Contact Type:_____
Name:_____
Phone Number:_____
Fax:_____
Address:_____

2**. This information may be released and used for the following purposes:**

- Allowing for coordination of services
- Confirm a Diagnosis
- Determine Program/Service Eligibility
- Treatment Planning
- Discharge Planning
- Emergency Contact
- Other:_____

3. **Protected Information that may be released and used**:

- All Records/Information
- Psychiatric Evaluation & Diagnosis Diagnostic Assessment
- Psychological Evaluation
- Addiction History and Assessment
- Addiction Treatment Records
- Social Service Case History
- Individual Community Support Plan
- Medical /Psychiatric/ Substance Use Disorder Records
- Labs
- Discharge Summary
- Behavioral Health History
- Crisis Plan
- Hospital Records
- Other:_____

***This release does not apply to psychotherapy notes as that term is defined under HIPAA.**

4. **I understand my PHI is protected by federal confidentiality rules, including 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. In addition, 42 CFR Part 2 prohibits the re-disclosure of information from programs it governs.**
5**. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance upon it.**
6**. I understand that my PHI may include information relating to sexually transmitted diseases, sickle cell anemia, AIDS, HIV, behavioral or mental health services, and treatment for alcohol and drugs.**
7. **Treatment may not be conditioned on my agreement to sign this form. I acknowledge that failure to sign this form may result in The Remedy's inability to provide adequate services as a result of limited ability to provide coordination of care.**
8. **This authorization will remain valid for a year from the date it is signed or until I revoke it in writing**.

My Signature indicates that I have read and understood this form, accept its terms and authorized of my information as described above.

Remedy Staff Signature_____ Patient Signature:_____Date_____