Name
Address line 1
Address line 2
Phone number

RELEASE/REQUEST AUTHORIZATION FOR CONFIDENTIAL IINFORMATION
Case Management

Client Name_______________________________________DOB:___________________
I authorize _____________________________________to:

Release_______________________________________and/or Request _____________information

To_____________________________________ and/or from_____________________________

Name:____

Address__ ___________________ ___________ _________ State_________Zip___________

Phone No. with area code:_________________________Fax No. with area code:______________

I authorize the following information to be released and/or requested:

____Discharge Summary
____Patient Progress Information
____Psychiatric History
____Case Conference
____Medical History/Physical Exam
____Clinical (Lab, X-Ray, EKG, EEC, etc.)
____Consultations
____Diagnosis
____ Legal History
____Other_________________________________
__ Psychological, Neurological Testing, etc
__Psychological or Psychiatric Condition
___Physician Orders
___Education Information
___Alcohol /Drug Abuse History
___Social History
___Intake/Admission Information
___Current medications
___Claims Administration/Payment

The purpose of disclosure is for: ______Case Management

Authorization:
I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time. This information is disclosed pursuant to C.F.R. Sec 42, part 2. I understand that if anyone who receives my confidential information is not bound by confidentiality, my confidential information may not be protected by federal privacy laws if my confidential information is re-disclosed by the recipient of this information.

Date of Expiration:_______________________ . This authorization shall remain in effect for a period of one year unless otherwise specified. This authorization may be revoked by me, in writing, at any time.

X____Date:______________________________
Signature of Client/Legal Guardian

X____Date:______________________________
Person authorized to sign for client (Name/Authority)

If revoking this Release sign here:____Date:_________________

Witness:___________________________________Date________________