MidValley Healthcare

Release of Information Consent

Client's Name: ____ DOB: ______________

Address: __________________________City: ________State: ________Zip: ______

Phone: ______________________

I, ____________________, authorize MidValley Healthcare to: ◯ (send) and/or ◯ (receive) the following

To/From:

Name: ____Relationship to Client:_______________________

PCP, Counselor, Spouse, etc.

Address: _______________________ City: ________ State: ________Zip: ______

Phone:___________________________Fax:________________________________

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR PSYCHOTHERAPY NOTES.

______ Chemical Dependency evaluation
______ Chemical Dependency progress notes
______ Psychiatric evaluation
______ Psychiatric progress notes
______ Psychotherapy evaluation
______ Psychotherapy progress notes
______ Group Therapy progress notes
______ Treatment plan
______ Discharge summary report
______ Labs
______ Psychological testing
______ Others, specify _______________________
______ Others, specify _______________________
______ Others, specify _______________________

The above information will be used for the following purposes:

______ Planning appropriate treatment or program
______ Continuing appropriate treatment or program
______ Determining eligibility for benefits or program
______ Case review ______ Updating files
______ Other (specify) ______________________________________

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after one (1) year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: ___________________________ Date ____/_____/ ____

Parent/guardians/personal representative (if applicable)

Signature: _____________________________ Date ____/_____/ ____

Your relationship to client: ____Self ____Parent/legal guardian ____Legal representative ____Other:____________________

Witness (if client is unable to sign)

Signature: _____________________________ Date ____/_____/ ____