



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.

- | | |
|---|---|
| <input type="checkbox"/> Chemical Dependency evaluation | <input type="checkbox"/> Treatment plan |
| <input type="checkbox"/> Chemical Dependency progress notes | <input type="checkbox"/> Discharge summary report |
| <input type="checkbox"/> Psychiatric evaluation | <input type="checkbox"/> Labs |
| <input type="checkbox"/> Psychiatric progress notes | <input type="checkbox"/> Psychological testing |
| <input type="checkbox"/> Psychotherapy evaluation | <input type="checkbox"/> Others, specify _____ |
| <input type="checkbox"/> Psychotherapy progress notes | <input type="checkbox"/> Others, specify _____ |
| <input type="checkbox"/> Group Therapy progress notes | <input type="checkbox"/> 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 ___/___/___