FAMILY HEALING CENTER

Authorization of Release
of Records or Information

Client Name_____________________________________ Address ________________________________

City, State, Zip __________________________________ Phone ___________________________________

DOB _____________________ SSN _________________________

I _____________________ (name of client/guardian) hereby give permission to The Family Healing Center, LLC., herein referred to as FHC or any clinician performing services on behalf of FHC in connection with my/my child's treatment to

____ **Disclose Information to**: AND/OR _____**Obtain information from:**

____
(Name of agency, physician, attorney, school counselor, therapist, etc)

____
(Address, city , state, and zip code)

Phone: ( )________________________

(Name of agency, physician, attorney, school counselor, therapist,)

____
(Address , city, state, and zip code)

Phone: ( )_______________________________

____ **MY ENTIRE RECORD; OR**

___ **Only the following information: (Patient must initial each item to be released/ obtained:**

____Substance Abuse Evaluation
____ Treatment Recommendations
____ Expected Length of Treatment

_____Diagnosis/Assessment
_____ Treatment Plan
_____Treatment Provider

The purpose of this disclosure is:
___ to permit continuity of care,
___ to permit case management (including reimbursement determinations) and processing of benefit claims
____ Other (speciy)____

The timeframe within which this release of information is applicable is from: _______ to ________
(not to exceed 180 days)

The undersigned hereby authorizes and gives this consent voluntarily, I understand that I have a right to inspect the information being released as permitted under the Privacy Rules. I also understand that the provision of the serviced solely for the purpose of creating information for disclosure to a third party or if I am receiving research related treatment.

I understand that the Provider cannot guarantee that the Recipient will not re-disclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information.

I understand that I may revoke this Authorization in writing at any time; except that the revocation will not have any effect on any action taken by the Provider in reliance on this Authorization before written notice of revocation is received by the Provider.

____ ________________________________

Signature of Client **Signature of Witness**

____ ________________________________

Signature of Client's Agent or Representative **Date Released**

Approved by: ______________________________
Information released: ____

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records where the confidentiality may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless disclosure is expressly permitted by the written consent of the person to whom it pertains, or as other permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

The release is subject to be revoked at any time, except to the extent that the program which is to make the disclosure, has already taken action in reliance on it.

_____________________________________ __________________________________

Signature of Client/Guardian Date **Approved by Date**