**Randall Minteer, LCSW-C**

**Release of Confidential Information**

This form, when completed and signed by you, authorizes your provider to release protected information from your clinical record to the person you designate.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize (Provider’s name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number \_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

and/or his/her administrative staff, to release the following information:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | History and Physical |  | Alcohol/drug assessments |  | Treatment Plan |
|  | Psychosocial Assessment |  | Medications |  | Alcohol/Drug TX records |
|  | X-Rays |  | Labs |  | Group Therapy Notes |
|  | Psychiatric Eval/Tests |  | Discharge Summary |  | Psychotherapy Notes |
|  | Psychological Testing Results |  | Progress Notes |  | Other (Please specify) |
|  | EKGs |  | Physician Orders |  |  |

Information should only be released to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:

I am requesting my provider release this information for the following reasons (“at the request of the individual” is all that is required if you do not desire to state a specific purpose.

At the request of the individual

I understand that the provider cannot re-disclose information received from another health care provider if that health care provider requested that the information not be re-disclosed.

This authorization shall remain iin effect until one year from the date below or until: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the provider’s office. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this athorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand this authorization is voluntary. I undertand that if the persons or organizations I authorize to receive and/or use my health information may not be subject to the federal or state health information privacy laws, they might further disclose the health informatinop, and it may no longer be protected by the HIPAA Privacy rule. If the request for information concerns treatment of alcohol or other substance abuse, the confidentiality of the information is protected by federal law 42 CFR Part 2. I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my intent.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/guardian Date

If the authorization is signed by a personal representative of the patient, a description of such representative’s authority must be provided.