Release of Information

By signing below,

I hereby authorize the disclosure of information in the medical record of the patient identified above which includes information that may be stored in a paper and /or other electronic format. Such records may contain information on demographics; financial/insurance information; general medical care; alcohol and drug abuse treatment; psychiatric treatment; behavioral or mental health treatment; HIV or AIDS; AIDS-related treatment; sexually transmitted diseases or infections; venereal disease; tuberculosis; hepatitis. Disclosure shall be limited between the listed entities and to the information obtained during the course of treatment. (For Perinatal Clients) I authorize the release and/or exchange of my protected health information for the purpose of coordinating care related to pregnancy, childbirth, postpartum recovery, maternal mental health, infant bonding, or parenting support.

CLIENT INFORMATION

Client's name:_____

Client's Date of Birth:_____

REQUEST OF MEDICAL RECORDS

☐ Check here only if you are requesting copies of your own medical records

I AUTHORIZE CHOOSING HER WELLNESS CENTER TO:

☐ Release Information

☐ Obtain Information

TO/FROM PERSON(S) INFORMATION:

Name:_____

Relationship to client:

☐ Self

- [ ] Emergency Contact
- [ ] Legal guardian
- [ ] Family Member
- [ ] DCF
- [ ] Probation/Parole
- [ ] Primary Care Physician
- [ ] Psychiatrist
- [ ] OB/GYN or midwife
- [ ] Doula or birth support person
- [ ] Partner, co-parent, or other support people
- [ ] Pediatrician (for mom-baby connection)
- [ ] Other: _____

Address:_____
Phone Number:_____
Email:_____
Fax Number:_____
How the information may be shared (e.g. phone, email):
_____
_____
_____
_____

THE FOLLOWING INFORMATION REQUESTED/OR TO BE RELEASED (CHECK ALL THAT APPLY):

- [ ] Psychiatric diagnosis(es)
- [ ] Initial treatment Plan
- [ ] Dates of Treatment
- [ ] Therapy Compliance
- [ ] Other: _____

THE ABOVE INFORMATION WILL BE USED FOR THE FOLLOWING PURPOSES:

- [ ] Planning appropriate treatment or program

☐Continuing appropriate treatment or program
☐Legal Matters
☐Referral Purposes
☐Medical Care
☐Coordination of care with a psychiatrist
☐Vocational
☐Family Involvement
☐Insurance /Payment
☐Education
☐Housing Support
☐Coordination of care with OB/GYN, midwife, or doula
☐Involvement of a partner or support person in treatment
☐Coordination of care with a psychiatrist regarding medications during pregnancy or postpartum
☐Other:_____

STATE AND FEDERAL LAW PROTECTED INFORMATION:

State and Federal law protects the following information listed below. Please check **and** initial next to each type you agree to release.

I authorize the release of the following information:

☐Alcohol and / or Substance Use Treatment Record _____
☐HIV /AIDS Testing, Results, and Record_____
☐Mental Health Record_____
☐Domestic Violence or Sexual Assault records_____
☐Sexual or Reproductive Health Information_____
☐Genetic Testing_____

DATES OF SERVICE REQUESTED:

The dates of service requested correspond to the time period during which treatment occurred. If you wish to limit the release to specific dates, please indicate those dates:

_____

I understand that this information may be protected by Title 45 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 42 (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 information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws. I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires or if services are terminated prior to the one year if otherwise specified. Revocation will not apply to information disclosed prior to receiving notification of revocation. 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 and treatment will not be contingent on signing this authorization.
I have carefully read and understand this authorization and have had any questions answered to my satisfaction. By signing below, I do hereby expressly and voluntarily authorize disclosure of the above information regarding my health to those persons or agencies listed above.
If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization and documentation to receive this protected health information.

Signature:_____
Date:_____
Witness signature (if client is unable to sign):_____
Witness Name:_____
Witness Date:_____