ASPIRE NETWORK
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Authorization for Release of Information

I,_____DOB:_____, authorize **Aspire Network**

To:
⊓ obtain information from

□ release information to
□ exchange information with

Information With

Name: _____

Address: _____

Phone: _____ Fax: _____

The following information:
□Clinical Progress Notes
□Diagnostic Assessment
□Individual Treatment Plan
□Functional Assessment
□Chemical Health Information
□Verbal Communication

□Individualized Education Plan
□History and Physical
□Medications
□Neuropsychological/Psychological testing
□Psychiatry Assessment and Clinical Notes
□Other:_____

Purpose for disclosure: _____

Patient Restrictions on Methods for Disclosure:
I understand that communication of the items can occur:
□ Verbally □ In-person conference □ Mailed or faxed medical record/correspondence

I understand that:
*My health information is protected by federal regulation (Alcohol and Drug Abuse Patient Records, 42 CFR Part 2: and/or HIPAA 45 CFR) and state privacy laws and disclosure is allowed only with my authorization except in limited circumstances described in Aspire Network's Privacy Notice. I understand that I have a right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws.

*I can revoke this authorization at any time except to the extent that action has been taken in reliance on it. Aspire Network's Privacy Notice outlines the procedure for revocation. This authorization will expire in one year from the date I sign or unless I request an earlier expiration in writing.
*This Authorization for Release of Information will remain in effect until:
(defaults to 1 year from the most recent date (form date or client signature date) unless explicitly entered).

*For disclosures other than for treatment, payment. and healthcare operations purposes. treatment may not be conditioned on my agreement to sign and authorization (unless ı am receiving care solely to create protected health information for disclosure to a third party) (45 CFR & 164.508 (b)(4)(111)

*Communications resulting from this authorization will reveal that I receive services at Aspire Network

*Federal confidentiality regulations (at 42 CFR Part 2) prohibit re-disclosure of information from alcohol and drug abuse patient records. However, HIPAA requires Aspire Network to notify me of the potential that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by HIPAA rules.

*This authorization may be used by Aspire Network-owned or managed programs upon transfer of my care to them.

* Information to be disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise 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.

Patient's Signatures: _____ Date: _____

Staff Signature: _____ Date: _____