Insight Renewal Center
2723 Foxcroft Rd, Suite 202 B
Little Rock, AR 72227
Email: info@insightrenewalcenter.com
Phone: 501-414-0111 Fax: 501-222-1309

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION; HIPAA Privacy Rule 45 C.F.R., AND, ANDDENTIAL INFORMATION; Section 164.508 Welfare and Institutions Code, Section 5328 (c)

Only complete this form if you are requesting that Insight Renewal Center shares or obtains your previous or ongoing treatment information for purposes of referring you to a provider or treatment facility. Only complete this form if you are requesting that Insight Renewal Center shares information with any other entity or agency

Client's Name _____ Birth Date _____(MM/DY/YR)

I, _____

(*Name of Client or Guardian if client is under 18 y/o*)

hereby authorize Insight Renewal Center: _____ to release or disclose the following protected health information or other confidential information:

- Diagnosis Psychiatric Evaluation Information
- Treatment Information
- Medication Information
- Social Security Number
- Address and Telephone Number
- Date of Birth
- Other(specify)
  - _____
    _____
    _____

To _____

Name of Agency/Person/Organization

_____

Address (Street, City, State and Zip Code)

For the purpose of:

_____
_____
_____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION HIPAA Privacy Rule 45 C.F.R., AND CONFIDENTIAL INFORMATION Section 164.508 Welfare and Institutions Code, Section 5328 (c)

By signing this authorization:

• I authorize the use or disclosure of my protected health information and confidential information as described above for the purpose listed. I understand that this authorization is voluntary.

• I understand that I have a right to receive a copy of this authorization.

• I understand that I may revoke this authorization at any time by submitting a signed letter addressed to the Insight Renewal Center, LLC, 2723 Foxcroft Rd, Suite 202B, Little Rock, AR 72227, stating that I wish to revoke this authorization to release my protected health information and confidential information. I understand I may email my signed revocation letter to the Insight Renewal Center's email address at info@insightrenewalcenter.com. If revoked, the authorization will stop on the date the request is received or specified in the revocation letter. [45 C.F.R. § 164.508(c)(2)(ii)& Civil Code § 56.11(h)] If not revoked, it shall terminate at the end of (check one): ☐ 6 months ☐ One year ☐ at Discharge or Specify Date

_____ _____

Signature of Client (MM/DY/YR)

_____ _____

Signature of Parent/Guardian/Conservator, if Applicable (MM/DY/YR)