**AUTHORIZATION FOR RELEASE / REQUEST OF CONFIDENTIAL INFORMATION**

**IN CASE OF EMERGENCY OR EMERGENCY CONTACT PERSON**

**I,** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SS#**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization For: [X ] RELEASE OF INFORMATION [ X] REQUEST FOR INFORMATION

I, authorize **Sojourners Recovery and Wellness Center, LLC.** and/or **Family4Today, INC.** To release information contained in my medical record and/or financial statement to: (please provide name/address/phone number and relationship of person of where information is to be released) or who may release information:

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

I understand that my records are protected under **Federal Confidentiality Regulations (42 CFR Part 2) published August 10, 1987, and the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. Seq** and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions. I understand that if this information is faxed, that confidentiality cannot be guaranteed.

**PURPOSE OF REQUEST/RELEASE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I SPECIFICALLY AUTHORIZE RELEASE OF THE FOLLOWING:**

­\_\_\_\_\_\_­ Medical History & Physical Examination \_\_\_\_\_\_ Admission/Evaluation Summary (ies)

\_\_\_\_\_\_ Progress Notes ­­ ­ \_\_\_\_\_\_\_ Psychological Evaluation

\_\_\_\_\_\_ Staff Conference/Treatment Plans & Reviews \_\_\_\_\_ Physicians Orders

\_\_\_\_\_\_ Discharge Summary \_\_\_\_\_\_ Discharge Treatment Summary

\_\_\_\_\_\_ Consultation Reports \_\_\_\_\_\_ Laboratory & X-ray Reports

\_\_\_\_\_\_ Other: Copies as needed for treatment \_\_\_\_\_\_ Acknowledgement of Presence

\_\_\_\_\_\_ Entire Contents of my Client Chart \_\_\_\_\_\_ Disclosure of Treatment Process

I understand that I may revoke this authorization at any time upon written notice to Sojourners Recovery and Wellness Center and/or Family4Today. I acknowledge that such revocation will not be effective if Sojourners Recovery and Wellness Center and/or Family4Today has already acted in reliance upon this authorization. I hereby release Sojourners recovery and Wellness Center and/or Family4Today from any liability which may arise as a result of the use of the information released in accordance with this authorization.

This authorization is valid (if not previously revoked) this consent will terminated upon 90 days from the date of signature of this form or the following event/condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, upon the completion of treatment, or at the time of the final insurance billing, as the case may be, whichever is later.

TO RECEIVING AGENCY: This information has been disclosed to you from records whose confidentiality is protected by Federal Confidentiality rules. Any further re-disclosure is prohibited.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Client’s Signature Date Staff Signature Date

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Sojourners Recovery and Wellness Center and/or Family4Today. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

**I HEREBY REVOKE THIS RELEASE OF IFORMATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Client’s Signature Date Staff Signature Date