SANTA ROSA COUNSELING CENTER

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Last Name First MI Date of Birth SSN

This document authorizes **Santa Rosa Counseling Center, LLC** to release and obtain information from protected records to include: medical, mental health, substance abuse, academic, and vocational treatment. The release of third party information, including records received from other providers if requested, is authorized unless otherwise specified or prohibited. This information may be released verbally, in copy form, or electronically to include fax and/or computer transmission. The releasing agent is authorized to act on behalf of a copy of this original form.

Person or Agency to Obtain and/or Release Information *(may include multiple parties)*

The extent or nature of use / disclosure is limited to the following information as checked below:

☐ Psychiatric / Psychological Evaluation
☐ Treatment Summary / Recommendations
☐ Treatment Plan
☐ Discharge Summary
☐ Progress Notes / Report
☐ Therapy Notes
☐ Medical History / Physical
☐ Medication Log
☐ Physician Orders
☐ Dates of Attendance / Verification
☐ Other: _____

I acknowledge that I am giving permission to disclose or obtain protected health information. I understand that I may refuse to sign this authorization or that I may revoke this authorization in writing at any time except for that action which has already been taken to comply with it. I understand that treatment may not be conditioned on whether I sign this authorization, but that in certain limited circumstances I may be denied treatment if I refuse to sign this authorization. There is a potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and, therefore, no longer protected by the provisions of the HIPPA Privacy Rule. I understand that if I am a criminal justice system referral, this consent will remain in effect and cannot be revoked by me until there has been a formal termination of my probation, parole, conditional release, or other proceeding under which I was mandated into treatment.

This authorization is valid until termination of services unless specified: _____

Patient Name | Patient / Guardian Signature | Date

Witness Name | Witness Signature | Date

PROHIBITION ON REDISCLOSURE: This information has been 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.