RELEASE OF INFORMATION AUTHORIZATION

CLIENT NAME	DATE OF BIRTH
Client Phone	Record #

I authorize Restore Outreach Center, LLC to:

☐ Disclose ☐Receive or ☐ Exchange information as noted below

Doctor or School Entity (Please compete for whom you wish us to communicate with):

Entity and/or Organization	
Department and/or Person	
Phone	
Fax	

Purpose of Disclosure: ☐ Coordinate Treatment/Services ☐ To gather assessment information for treatment planning
☐to gather information for ongoing treatment
☐ Continuity of care ☐ Legal
☐ Other (specify): _____

Type of Information to be Disclosed:

☐Mental Health Assessments/Summaries ☐Diagnosis ☐Diagnostic Assessment Information
☐Treatment Plan ☐Progress Notes ☐Discharge Summary
☐Progress in treatment ☐Information on behavioral/mental health treatment
☐Attendance ☐Other (Specify):

Amount of information to be Disclosed/Obtained:

☐ Information from the most recent admission ☐Information for Dates (Specify): _____

Restore Outreach Center, LLC will not condition treatment, payment, enrollment, or eligibility on the client's authorization for this release of information. Client may revoke this release of information upon request. Unless otherwise revoked in writing, this authorization will expire one year from the date this authorization, or the date indicated: _____

Signature of Client or Person Authorized to PERMIT Disclosure:	**Relationship to Client:**	**Date:**
Staff Signature or Witness:		**Date:**

Revocation: This Authorization is subject to written revocation at any time except to the extent of the program or person whom is to make the disclosure and has already acted in reliance on it. ☐**I am revoking this release of information by Restore Outreach center, LLC.**

Signature of Client or of other Person Authorized to REVOKE Disclosure:	**Relationship to Client:**	**Date:**
Staff Signature or Witness:		**Date:**

Prohibition Against Re-Disclosure: 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. Drug abuse patient records are also protected under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 CFR, Parts 160 and 164. (These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.)

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