AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Date:

Client Name:

I authorize Cynthia Rose and the person/entity named below to release my protected information described in this release **to/from** each other for the purposes described in this release.

_____

Name of insurance company, person, organization or facility to receive health information

_____

Street address:

_____

City

_____

State, Zip Code

_____

Phone Number

_____

Fax Number:

_____

Email:

The purpose of this release is for (check one or more):

□ Health Insurance Billing/Authorization

□ Obtaining or maintaining insurance or insurance benefits

□ Billing and payment of bill

□ Continuity of care or discharge planning

□ At the request of the patient or patient representative

□ Criminal justice involvement
□ Coordination of treatment with family or significant others

□ Current Care- After Care Recommendations and Medications

□ Other (state reason):

The information identified below and date/dates of service to be released:

Type(s) of health information (check one or more):

[ ] Presence in treatment. **[ ] Prognosis**/ Diagnosis

[ ] Nature of project. **[ ]** Relapse/frequency of relapse.

[ ] Brief description of progress.

Other (Please specify) _____

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:

□ _Information pertaining to drug and alcohol abuse, diagnosis or treatment (§§42 C.F.R. §§2.34 and 2.35).

□ _Information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §§ 5328, *et seq.*)

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires (insert applicable date or event). If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

_____ _____

Print Name Signature (Client, Parent, Guardian)

_____ _____

(Date) Time Parent, Guardian, Conservator, (Patient

Representative)

Requested format: □ Paper □ Electronic

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NOTICE

Information may be disclosed for the purpose of receiving payment from Third Party Providers. If I do not want my information released to a Third-Party Provider for payment purposes, I understand that I will be considered a full fee client and responsible for the payment of services received.

Cynthia Rose and others, organizations, and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2 and 42 USC). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2.32. 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 client, except as provided by 2.12 (c)(5) and 2.65.

YOUR RIGHTS This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative.

You are entitled to receive a copy of this authorization.