SPEEDY SAP
KEEPING COMMUNITIES SAFE

Doing Business As…

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Records Release Authorization

By signing this form, confidential psychological and psychiatric information can be released to and / or discussed with the people or agencies including employers, CSO's/ISO's, PO, Attorneys, Judges, other legal representatives, and agencies listed below unless noted by exclusions or limitations. This form is signed voluntarily and may be revoked at any time. All disclosures made pursuant to this form are valid as long as they were made before the date of revocation.

Patient Name: _____ Patient DOB:_____

1. I authorize my provider, Christy L. Foos-Farrow, LSCSW, LCAC to **RELEASE (initial here)_____ RECEIVE (initial here)_____** psychological / psychiatric mental health and substance use disorder information to/from the SECOND PARTY as directed below:

2. SECOND PARTY

   Name: _____

   Address: _____Email:_____

   Fax Number: _____ Phone Number: _____

3. TYPE OF INFORMATION TO BE DISCLOSSED

   (initial here)___I authorize disclosure of all health information, including data relating to medical, pharmacy, urine samples and breathalyzer testing results, substance abuse, diagnostic screening instrument results, clinical interviews, legal information, and psychotherapy, living environment that might impact mental health

   (initial here)___I authorize only the disclosure of the following information:_____

4. PURPOSE

   (initial here)___ My health information is being disclosed at my request or at the request of my personal representative; CSO/ISO, Legal Representative, or

   (initial here)___ My health information is being disclosed for the following reasons:_____

5. **(initial here)_____**Note any exclusions or limitations here: _____

I understand that treatment, payment, enrollment in a health plan, or eligibility for benefits is not dependent on my signing this authorization. By signing below, I acknowledge that I have read and understand this document and that I have voluntarily given my provider authorization to disclose my records. I understand that I may revoke this authorization at any time by providing a written notice to my provider, however the revocation will not influence any actions taken prior to the date my revocation is received. I understand that my information may be redisclosed by the authorized person/organization receiving the information, and at that point, the information may no longer be protected under the terms of this agreement. **This authorization will expire one year following the date signed unless revoked in writing.**

Signature: _____ Date: _____
Authorization is given on this patient's behalf due to being a minor or unable to sign.

_____ Date: _____
Legal Guardian / Personal Representative Signature: