ON SOLID GROUNDS

CONSENT RELEASE OF INFORMATION

Name

_____

DOB

_____

I authorize

Therapist Name

_____

Therapist Address

_____

To disclose and obtain treatment information from the following:

Name

_____

Address

_____

Phone

_____

Email

_____

Please sign below if you agree to release ALL of your Protected Health Information

If you are limiting the information that is released, please list ONLY the information you agree to be released:

By signing below I acknowledge that the above information about me may be released, discussed, or disclosed. I understand that my records are protected under Federal Regulations governing Confidentiality of Protected Health Information (PHI) under HIPAA and Confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2 and cannot be disclosed without my consent unless otherwise provided for the regulations. I also understand that I may revoke this authorization at any time and must do so in writing and present this written revocation to my therapist. I understand that once information is disclosed as per my authorization, the recipient, in accordance with the applicable laws and regulations, may re-disclose the information and it might not be protected by federal or state privacy regulations.

Signature of Patient

_____

Signature of Witness

_____

Date Signed

_____

Printed Name of Witness

_____