The Healthy Foundations Center
Authorization for Release of Information

Client Information

Name: _____ **DOB:** _____
Age: _____ **SSN:** _____
Guardian Name: _____ **Phone Number:** _____
Address: _____ **City, State, Zip:** _____

I hereby authorize THE HEALTHY FOUNDATIONS CENTER to (check all that apply):

☐ Exchange with ☐ Release to ☐ Obtain from **the parties I have indicated below**

Person/organization receiving/communicating the information:

Name:_____

Address:_____

City State Zip: _____

Phone Number: _____ Extension: _____

I hereby authorize THE HEALTHY FOUNDATIONS CENTER to exchange / release / obtain information:

☐Verbally only ☐in written form only ☐both verbally and in writing

Information to be Released

☐ **Entire Record**
☐ **Mental Health Records Only**
☐ **Treatment Attendance/Participation**
☐ **Seclusion or Restraint Information**
☐ **Individual Treatment Plan**
☐ **Other (Please Specify):**

_____

☐ **Mental Health Diagnosis**
Specify: _____
☐ **Evaluation/Assessment:**
☐ **Behavioral Health** ☐ **Bio-psychosocial** ☐ **Psychiatric**
☐ **Other (Please Specify):**_____
☐ **Tests/ Results (Please Specify):** _____

_____

I authorize this release to include information on services I have received for: ☐ Mental Health ☐ Substance Abuse ☐ **Other (Please Specify):** _____ **X** _____

Description of how the information will be used

☐ Evaluating ☐ Monitoring Progress or Participation ☐ Planning Treatment/Case Management
☐Assessing Services ☐ Client / Patient Request ☐ Court Ordered / Mandated ☐ Third party payment contract

The dates of records to be disclosed: From (_____) To (_____)

THE CLIENT OR THE CLIENT'S REPRESENTATIVE MUST READ AND SIGN OR INITIAL THE FOLLOWING STATEMENTS:

I understand that this authorization will expire:

☐On _____ (MM/DD/YYYY) or one year from the date of the signature below (or as set forth by other applicable federal or state law – see below).

OR

☐Once the following event occurs_____

The Healthy Foundations Center

I understand that this authorization is voluntary. I understand that mine or my child's health and mental information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that mine or my child's health and mental information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or treatment care provider, the released information may no longer be protected by the Federal privacy regulations.

I understand that mine or my child's records may contain information regarding mine or my child's mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below. I also understand that mine or my child's Behavioral Health information may be released to the Court and Probation Officers for review per their requests.

I understand that I may revoke this authorization at any time by notifying THE HEALTHY FOUNDATIONS CENTER in writing, but if I do, it will not have any effect on any actions THE HEALTHY FOUNDATIONS CENTER took before it received the revocation.

(Form must be completed before signing)

_____ _____

Signature /Legal Guardian Date

_____

Print Name and Relationship to the Client

_____ _____

Witness Signature Date of Witness Signature

I may receive a copy of this form after I sign it. **Initials**: _____

A copy of this form has been requested and received: _____ Yes _____ No **Initials**: _____(patient)

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION