AUTHORIZATION OF RELEASE OF RECORDS OR INFORMATION

I, _____(name of client), DOB_____/_____/_____
Acknowledge this authorization is voluntary. I understand that [organization name] will not base services on my signing of this document. I hereby give permission to [organization name] to release information as noted below:

My victim/partner's name: _____

Address of Individual/Agency		
City	***State***	***Zip Code***
Area Code	***Phone Number***	

___ *My entire record;* ***(initial OR)***

Only the following information (initial** all that apply**):

☒ **Any information that** [organization name] **determines presents a heightened safety risk to my partner _____**

☒ **Assessment _____**	☐ Treatment Plan _____
☒ **Treatment Recommendations _____**	☐ Name of new treatment provider _____
☒ **Expected length of treatment _____**	☐ Other Evaluation (Specify) _____
☒ **Attendance Records _____**	_____
☒ **Progress Report of my treatment _____**	☐ Diagnosis _____
	☐ Other _____ (Specify):_____

Form in which the information should be released (initial** bold options**):

☒ **Verbal** ___
☒ **Written** ___
☐ Photography ___
☐ Video ___
☒ **Other**: **Electronic** I authorize [organization name] staff to communicate by means of E-mail, fax and cordless or cellular telephones, where the use of these means is expedient or timely. ___

The purpose of this disclosure is to permit (initial** at least one**):

☒ **Continuity of care** ___
☐ Case management ___
☐ Reimbursement/processing of benefit claims ___
___ Other: _____

I understand that my records may contain protected information regarding diagnosis and/or treatment for : HIV/AIDS virus, other sexually transmitted diseases, drug/alcohol diagnosis and/or treatment and/or psychiatric or mental health care and diagnosis.
Please **initial** the statements that apply:

I give consent to release my HIV (AIDS virus) diagnosis/treatment information _____.

I give consent to release my drug/alcohol/substance diagnosis/treatment information. _____.

I give consent to release my psychiatric diagnosis/treatment information _____.

~ O V E R ~

The timeframe within which this release of information is applicable is (**initial** one option):

___ a period not to exceed one year from the date this is signed

___ a time period from _____ to _____

___ an event (describe event:) **Completion of the Program and/or 90 days after Discharge**

*If more than one box is checked, the authorization will expire by whichever time period/event is sooner.

I may revoke this consent at any time by contacting [organization name] at [phone number] except to the extent that action has been taken in reliance upon it.

NOTE: Once information has been disclosed, [organization name] can no longer protect it from further disclosure.

I understand I have the right to receive a copy of this authorization form.

_____ Signature of Client	_____ Date (mm/dd/yyyy)
_____ Relationship:_____ Signature of parent, guardian, conservator, or authorized representative (when required)	_____ Date (mm/dd/yyyy)
_____ Signature of Witness/Notary	_____ Date (mm/dd/yyyy)