AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name: _____ **Date of Birth: _____**

Client Rights

- You may end this authorization (permission to use or disclose information) any time by contacting our office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

Client Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, legal court records, educational records, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the above identified patient. I authorize these agencies to share information by mail, phone, in person, fax and/or email contact. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

☐ I hereby authorize Back on Track LLC to **RELEASE** and **OBTAIN** my protected health information (PHI) to:
Name:
Address:
City: St: Zip:
Phone #:
Fax #:

Disclosure Scope for PHI Release

Disclosure may include the following verbal or written information: (check all that apply)

	Face sheet		Substance abuse tx records		Medication records
	Laboratory/diagnostic testing results		Progress & case notes		Psychosocial Assessment
	Discharge summary		Psychological eval/testing results		Psychiatric evaluation
	Behavioral health/psych consult		History & physical		HIV/AIDS lab results & tx history
	ER record report		School information		Summary of tx records & dates
	Other:		Information necessary to identify, diagnose, prognosis, or treatment for mental health, substance abuse (alcohol/drug use), and any other relevant information for the purpose of treatment.		

All information I hereby authorize to be obtained from the above identified source will be held strictly confidential and cannot be released by Back on Track LLC without my written consent. I understand that this authorization will remain in effect for one year and will expire on:_____ I understand that unless otherwise limited by state or federal regulation and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time. If client is a minor child, I verify that I am the legal guardian/custodian of this child and that to my knowledge no other authorizers are required to sign.

_____ _____

Signature of Client, Legal Guardian or Legally Authorized Representative *Date*

_____ _____

Witness *Date*