D.A.BLODGETT
ST.JOHN'S

AUTHORIZATION FOR RELEASE OF INFORMATION

Consumer Name: _____

Parent, Guardian or Authorized Representative (If Applicable): _____

I hereby authorize D.A. Blodgett – St. John's, its affiliates, subsidiaries and related entities to (select A and/or B):

☐ **A. Request information from:**

Individual/Organization Name: _____

Street Address: _____

City/State/Zip: _____

Telephone: _____

Email: _____

☐ **B. Release/Disclose Information from my D.A. Blodgett – St. John's record to:**

Individual/Organization Name: _____

Street Address: _____

City/State/Zip: _____

Telephone: _____

Email: _____

RECORDS TO BE RELEASED:

☐ Assessment/ISP
☐ Treatment Progress Report/USP
☐ Treatment Plan/Home Study
☐ Substance Abuse Evaluation/Treatment
☐ Mental Health Treatment Records
☐ Psychiatric Evaluation and Services
☐ Treatment Recommendations
☐ Other (Describe): _____

Specific Description of requested documents:

_____

FOR THE PURPOSE OF:

☐ Continuity of Care
☐ Reimbursement/Claims Processing
☐ Case Management
☐ Other (Describe): _____

IN THE FOLLOWING FORMAT:

☐ Verbal
☐ Written (Photocopy)
☐ Electronic (CD, Jump Drive, Email)

☐ Video/Photograph (this is not a media release) ☐ Other: _____

RELEASE OF HIV/AIDS, SUBSTANCE ABUSE & MENTAL HEALTH RECORDS

_____ Initial Yes, I authorize the release of any records regarding the diagnosis or treatment of HIV/AIDS or other sexually transmitted disease.

_____ Initial Yes, I authorize the release of any records regarding drug, alcohol, mental health, or psychiatric treatment.

SIGNATURE

I understand that:

- My information cannot be disclosed without my written informed consent unless otherwise provided by law.
- I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it.
- I have a right to receive a copy of this authorization form.
- Upon my written request, D.A. Blodgett – St. John's must provide me a record of any subsequent disclosures made for legal, administrative or quality assurance purposes.
- D.A. Blodgett – St. John's is not liable or responsible for information that I authorize D.A. Blodgett – St. John's to release to other parties.
- I am not required to sign this authorization. D.A. Blodgett – St. John's will not restrict or limit services if I refuse to sign.
- A true and exact photocopy/faxed copy of this authorization shall have the same effect as the original.

Please check one of the two options below:

☐ Unless I revoke this consent earlier, this consent will automatically expire 365 days after it is signed.

☐ This consent is for a one-time release ONLY.

_____ _____ _____

Signature of consumer, parent, guardian or authorized representative *Date of Birth* *Date of Signature*

STOP! Use this section ONLY if the consumer chooses to revoke this consent

This Authorization of Release of Records or Information has been revoked on: _____

_____ Consumer/representative signature

_____ Staff signature and credentials (if revocation given verbally)

NOTICE TO RECIPIENT OF INFORMATION

If the disclosure involves substance abuse treatment records, they are protected by Federal Confidentiality Rules, 42 CFR Part 2. Federal Rules prohibit further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient