AUTHORIZATION AND WRITTEN CONSENT FOR DISCLOSURE OF HEALTH INFORMATION "CONSENT"

Client's Name:_____
DOB_____ **SS# XXX-XX-**_____
I hereby authorize Renewed Hope Family Services to **___obtain information from**
___release information/copies of medical records to:
Name:_____
Relationship/Company:_____
Address:_____
Phone Number_____ **You may discuss items/categories listed below**

__Psychiatric Evaluation __Neurological Evaluation
__Psychological Evaluation __Medical History Evaluation
__Treatment Plan/Summary __Summary of Progress
__Discharge Summary __Biopsychosocial History
__Other_____
__Drug/Alcohol related information which is limited to: Whether or not you are in treatment, your prognosis, the nature of the treatment program, any relapse and frequency of relapse, and a description of your progress in treatment

__Verbal communication via telephone/in person __By mail or fax

For the purpose of:
__Continuity of Care __Medical Treatment
__Obtaining Insurance Eligibility or benefits __Obtain/Retain Employment
__Emergency Contact __Transfer Records to new Provider
__ Couples Therapy** __Other _____

***Both members participating in couples therapy have the right to all documentation pertaining to couples therapy. Any access to treatment records dated before or after couples therapy, by the by the non-identified client, requires additional consent by the identified client.*

All information will be handled confidentially and in compliance with the HIPAA Federal Privacy Act. **This consent will begin the date of this Authorization and will expire, on _____,** unless terminated by me sooner. I may revoke authorization in writing or orally at any time except to the extent action has been taken prior to my revocation. I have the right to inspect or obtain copies of any health information disclosed. A fee will be charged for copies of the record. My refusal to sign this authorization will not prevent me from obtaining treatment. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient.
I have read this authorization and understand the nature of this release.

Client's Signature (Guardian)_____ **Dated**_____

Witness Signature_____ **Dated**_____

TERMINATION OF THE THIS RELEASE REQUESTED ON _____ BY _____

Client's Signature (Guardian)_____ **Dated**_____

Rev 1/17