 

Authorization to Release Information

(Please check one)

\_\_\_\_\_ **Community Reach Center** \_\_\_\_\_ **Mountainland Pediatrics, Inc.**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Origin of Authorization: \_\_\_\_\_External \_\_\_\_\_Internal (Reach Center or Pediatrics)

Direction of Authorization: \_\_\_\_\_Outgoing \_\_\_\_\_Incoming

*I hereby authorize (Information Source Agency):*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*To release the following information (Information to Release)*:

\_\_\_\_\_Intake/Initial Assessment \_\_\_\_\_Psychological Evals/Reports \_\_\_\_\_ Treatment Plan

\_\_\_\_\_Lab Reports \_\_\_\_\_Monthly Summary \_\_\_\_\_HIV Status

\_\_\_\_\_Social History \_\_\_\_\_Progress Notes \_\_\_\_\_CCAR

\_\_\_\_\_Discharge Summary \_\_\_\_\_Progress Summary \_\_\_\_\_Medical Evaluation

\_\_\_\_\_Psychiatric Eval/Notes \_\_\_\_\_Drug/Alcohol History/Treatment

\_\_\_\_\_Claims/Billing Information \_\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*The information will be disclosed to (Information Destination Agency):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*For the purpose of (Reasons for Release):*

\_\_\_\_\_Assessment \_\_\_\_\_Service Planning \_\_\_\_\_Coordination/Continuity of Care

\_\_\_\_\_Benefits Coordination/Acquisition \_\_\_\_\_Legal Purposes \_\_\_\_\_Payment of Insurance Claims

\_\_\_\_\_Disability Determination \_\_\_\_\_Referral

\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (One year from creation, unless otherwise specified)

I understand Community Reach Center and/or Mountainland Pediatrics cannot condition treatment, payment, enrollment, or eligibility for benefits

on whether I sign this form or not. If the information authorized to be released pertains to diagnosis and treatment of alcohol and/or drug abuse, I

understand the information is protected by Federal Law 42, C.F.R. Part 2. I understand that there is potential for information disclosed, disclosed as

a result of this authorization, to be re-disclosed by the recipient and therefore no longer protected by the HIPAA Privacy Regulation. I understand

that I may revoke this authorization at any time by giving written notice to Community Reach enter and/or Mountainland Pediatrics, except to the

extent that action has already been taken to comply with it. Without such revocation, this authorization will expire one year from the date of my

signature unless otherwise requested at the onset of this authorization. I understand that I have a right to refuse to sign this form subject to the

conditions noted above. If I sign the form, I am entitled to a copy of that signed form.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed by (print name):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authority to Sign:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witnessed by (print name):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_