Triad Health Systems, Inc. Behavioral Health Services

AUTHORIZATION FOR RELEASE OF INFORMATION

I, ______________________________, ______________________, ____________________
(Full Name of Client) (S.S. No. /I.D. No.) (Date of Birth)

authorize and give this consent voluntarily. I have been informed of the specific type of information that is being requested/released. I also understand that refusal to sign this authorization in no way affects my treatment, payment or eligibility for benefits. I understand that I may inspect or copy my records prior to use or disclosure. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of any health information, I can contact the Privacy Officer at Triad Health Systems, Inc.

COMPLETE LEFT TO RIGHT (check appropriate boxes):

☐ **FROM**
Triad Health Systems, Inc.
____

☐ **TO** (Full name and address of individual/agency)
____
____

☐ **TO**
Triad Health Systems, Inc.
____

☐ **FROM** (Full name and address of individual/agency)
____
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TYPE OF INFORMATION TO BE RELEASED: (Check all that apply)**:**

___ Admission Summary
___ Psychiatric Eval.
___ Psychological Eval.
___ Current Medical Status
___ Progress Notes
___ Treatment Plans
___ Laboratory Tests
___ Discharge Summary
___ Other (Specify)______________________________

PURPOSE FOR RELEASE:

___ Report client progress
___ To obtain collateral information in treatment of this client.
___ Verify client attendance
___ Accompany client to appointments
___ Other (Specify)______________________________

SUBSTANCE/HIV/STD INFO TO BE RELEASED (check all that apply):

___ Treatment Information which may include Human Immunodeficiency Virus (HIV) Infection, Acquired Immunodeficiency Syndrome (AIDS), Or Tests For HIV.
___ Drug, Alcohol Assessments
___ Drug, Alcohol Treatment Notes
___ Sexually Transmitted Diseases
___ Other: ______________________________

AMOUNT OF INFORMATION TO BE RELEASED:

___ Information covering the most recent admission
___ Information covering the previous three months
___ Information from beginning to present
___ Other time frames (specify)______________________

TIME LIMITATION OF RELEASE: This authorization expires in (check ONLY ONE timeframe below that applies) from the date signed:

__30 days __60 days __3 months __6 months __ 1 year

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PROHIBITION ON REDISCLOSURE:

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by Federal Regulations. The 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.

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REVOCATION OF RELEASE:

This release is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. For the revocation of this authorization to be valid the revocation must be IN WRITING, a proper photo I.D. provided and signed.

___ RELEASE IS BEING REVOKED. *If client is REVOKING THIS RELEASE, you must complete a "RELEASE REVOCATION" visit, proper ID must be given and the Compliance Officer must be notified.*

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______________________________ ______________________
Signature of Client Date

______________________________ ______________________
Signature of Client's Parent/Legal Guardian Date

______________________________ ______________________
Witness Date

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STAFF INSTRUCTIONS: All INFORMATION ON THIS PAPER must be entered electronically and/or scanned into the patient record as soon as possible. This release of information must have the witness signature to be valid.