AUTHORIZATION FOR RELEASE OF CONFIDENTIAL AND

PROTECTED HEALTH INFORMATION

Client Name:____

Parent/Legal Guardian (if applicable): ____

Client Date of Birth: ____

Client Address (including city, state, and zip:

____

____

I give authorization and permission to RAFT and associated staff, contractions, and clinicians, to:

- ☐ Release information to
- ☐ Obtain information from
- ☐ Exchange information with

Name: ____
Phone: ____

Email Address/ Address: ____

This release includes the following information (check one or multiple):

- ☐ Verbal summary and discussion of treatment
- ☐ Record of attendance only
- ☐ Evaluations/Testing reports
- ☐ Treatment Plan
- ☐ Complete Medical/ Mental Health record
- ☐ Diagnosis/ Psychiatric conditions
- ☐ Drug/ Alcohol abuse information
- ☐ Treatment Summary
- ☐ Psychotherapy Notes
- ☐ Scheduling/ Billing
- ☐ Other: __________________________

RAFT Counseling Release of Information Form (ROI)

The purpose of this release is:

- ☐ Coordination of care
- ☐ Treatment planning
- ☐ Legal issues
- ☐ Testing/ Assessment
- ☐ Condition of court order/ parole
- ☐ At the request of the client
- ☐ Other: ______________________

(See CFR §164.508(c)(2)(i-iii)) I understand the following:

This authorization will expire in one (1) year from the date of signing, unless otherwise specified here:
Date authorization will expire: ____

• The disclosure of health information is voluntary, and I have the right to refuse to sign this authorization.

• I have the right to revoke this authorization in writing at any time, except to the extent information has already been released in reliance upon this authorization, by providing written notice to the provider's address on this form.

• The information released in response to this authorization may be re-disclosed to other parties by the recipient, in which case it would no longer be protected by federal privacy regulations. • Unless the purpose of this Authorization is to determine payment of a claim or benefits, my treatment or payment for my treatment cannot be conditioned on the signing of this authorization. • If I have authorized the release of Drug or Alcohol conditions, Federal Law (42 CFR Part 2) protects the confidentiality of this information.

I consent to all information provided here.

____
Client Signature Date

____
Parent/ Guardian Signature (if applicable) Date

____
Relationship to Client (if applicable)

Any facsimile, photocopy, or other reproduction of this authorization is authorization to release the requested information.