Public Health
Prevent. Promote. Protect.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name of Client: _____ Date of Birth: _____

Address: _____ Telephone: _____

The following programs are authorized to disclose/exchange information:

From Whom:	**To Whom:**
Physician/Site/Person Authorized to <u>RELEASE</u> Information:	**Physician/Site/Person Authorized to <u>RECEIVE</u> Information:**
Name:	**Name:**
Address:	**Address:**
Phone: **Fax:**	**Phone:** **Fax:**

Purpose of Disclosure: ☐ to coordinate treatment, ☐ assessment information for treatment planning, ☐ information for ongoing treatment, ☐ other purpose (specify): _____

Type of Information to be Disclosed: ☐ lab results, ☐ progress notes, ☐ prenatal care, ☐ diagnosis, ☐ response to treatment, ☐ treatment plans, ☐ BCMH, ☐ other information (specify): _____

Information which will NOT be Disclosed: ☐ HIV/AIDS testing or status, ☐ mental illness status or treatment, ☐ alcohol/drug addiction or treatment, ☐ BCMH, ☐ other information (specify): _____

Time Period to be Disclosed: ☐ information from the current/most recent admission/treatment episode, ☐ information for the period of _____ to: _____

I understand that TCHD shall not condition treatment, payment or enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure and that I MAY REFUSE TO SIGN THIS AUTHORIZATION.

_____ _____

Signature of Client or Legal Representative (Authority: POA, Guardian, Parent) Date

Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in one year from the date of signature.

Revocation: This authorization is subject to revocation at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it. Clients can revoke consent either verbally or in writing.

I hereby revoke my consent: _____

Client's Signature & Date

Re-Disclosure: I understand that the information authorized for disclosure above may be re-disclosed and no longer protected by Federal privacy regulations.

This facility, it's employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.