AUTHORIZATION TO RELEASE / OBTAIN INFORMATION

www.directionsforliving.org

Directions for Living
LIFE GETS BETTER HERE.™

Client Name:_____

DOB: _____

SS#: _____

Phone Number: _____

I hereby give permission to Directions for Living to:
_____Release / Provide Information to the agency or person listed below.
_____Receive / Request Information from the agency or person listed below
.

AGENCY OR PERSON: _____

ADDRESS: _____

PHONE #: _____ FAX#: _____

The Specific Information to be Disclosed is: (Circle either written (W) or verbal (V) or both)

W V Psychiatric Evaluation
W V Treatment Plan
W V Progress Notes (circle choice): Medical Clinical
W V Discharge Summary / Plan and Referrals
W V Psychological Testing
W V Treatment Summary (current status, meds, appointments)
W V Other (must specify): _____

W V History & Physical Examination
W V Lab, X-Ray, EKG, EGG, CT Scan
W V Reports of Consultation
W V Education
W V Drug/ Alcohol Treatment

This information is being released, received, and used for the purposes of coordinating my care, evaluating my needs, and/or providing services to me. I understand that I have the right to refuse to sign this authorization and that my treatment is not contingent upon whether or not I sign this authorization.

I further understand that I am agreeing to share confidential information that is protected by state and federal laws governing confidentiality of alcohol, drug abuse, mental health, and HIV patient records (42 CFR Part2; FS 394; FS 381). Although anyone who receives my records from this Organization is not permitted to release them to anyone else without additional written consent, I understand that Directions can not guarantee that subsequent redisclosure will not happen. I hereby release the issuing Organization/person from any liability, which may arise as a result of the use of the information contained in the copies of records released, as a result of this authorization, if such information is later used to my detriment.

THIS AUTHORIZATION IS FOR a single ☐ or continuing ☐ disclosure, valid for two (2) years after the date of my signature as it appears below, or from _____ to _____. This authorization may be revoked at any time upon written notification by the signatory or client, but revocation has no effect on action previously taken.
I have been offered a copy of this authorization.

Signature of Client: _____ Date: _____

Signature of Legally Empowered Representative: _____ Date: _____

Relationship to Client: _____

Signature of Witness: _____ Date: _____

For use by Directions For Living only
Abst____ Medical only____ Clinical ONLY_____ Med Log ____ TX Plan____ Progress Notes____
PE____ Other_____ Date_____ Page count_____ Initials_____

Client Name: _____ Client #: _____