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Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information)

Patient Name	Date of Birth	
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

7. Purpose for Release of Information:

8. Unless previously revoked by me, the specific information below may be disclosed from: _____ until _____
INSERT START DATE INSERT EXPIRATION DATE OR EVENT

All health information (written and oral), except:

For the following to be included, indicate the specific information to be disclosed and initial below.

- Records from alcohol/drug treatment programs
- Clinical records from mental health programs*
- Records from medical providers

	Information to be Disclosed	Initials

9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:
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All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

 SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY
 LAW

 DATE

 STAFF PERSON'S NAME AND TITLE

 SIGNATURE

 DATE

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.