**AUTHORIZATION TO RELEASE/REQUEST CONFIDENTIAL INFORMATION**

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I request protected health information (PHI) for the above-named client from Great Plains Mental Health Associates (GPMH) to be:** \_\_\_\_\_ Released and/or \_\_\_\_\_ Requested

**Send Information to/from:**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AGENCY (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This information is requested for the purpose of:**

\_\_\_\_\_ Further Treatment Services \_\_\_\_\_ Insurance Eligibility/Benefits \_\_\_\_\_ Legal Action/Proceedings

\_\_\_\_\_ Personal/Request of Service Recipient \_\_\_\_\_ Treatment Coordination/Progress

\_\_\_\_\_ Other (Please Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ \*Substance Use (For Dual Treatment Only): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \*Signature of minor required for release of substance abuse records

**NOTICE TO RECIPIENTS: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by CFR-42, Part 2. A 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. Source: 42 CFR 2.1 to 2.67 (October 1, 2000 ed.)**

**Information to be released:**

\_\_\_\_\_ Treatment Summary \_\_\_\_\_ Psychological Evaluation/Testing \_\_\_\_\_ All Available Information

\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release Format:** \_\_\_\_\_ Paper \_\_\_\_\_ Electronic

**Release Method:** \_\_\_\_\_ Fax \_\_\_\_\_ Mail \_\_\_\_\_ Pick Up \_\_\_\_\_Verbal \_\_\_\_\_ Other

**By signing this authorization form, I understand that:**

* I have the right to revoke this authorization at any time. Revocation must be made in writing to GPMH provider at the address listed above. Revocation will not apply to information that has already been disclosed in response to this authorization.
* Unless revoked, this authorization will expire in one year from the date signed or on the following date, whichever occurs sooner. Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization; I understand that I have the right to refuse to sign this authorization.
* Any disclosure of information has the potential for re-disclosure and may not be protected by federal confidentiality rules.
* Requests for copies of records may be subject to fees in accordance with applicable law.

**Patient printed name and signature:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Custodian printed name and signature (if above patient is a minor):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**