rivervalley & affiliates

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

The undersigned hereby authorizes the release of information from the health record of:

1. Client Name:_____ Last 4 #s of SSN:_____

   Date of Birth:_____ Phone Number:_____

2. **INFORMATION TO BE RELEASED FROM:** **INFORMATION TO BE RELEASED TO:**

   _____ _____

   _____ _____

   _____ _____

   Phone/Fax:_____

3. **INFORMATION AUTHORIZED FOR RELEASE (MARK "X" BY ALL THAT APPLY):**

   ____ Psychiatric Evaluation ____ Medication History ____ Psychological Evaluation
   ____ Psychiatric Progress Notes ____ Medical/Physical History ____ Therapy Progress Notes
   ____ Nursing Notes ____ Discharge Summary ____ Lab Reports
   ____ Psychosocial Assessment ____ Physical Health Notes

   ____ Other type:_____

   ____ Above information from the following time period:_____

4. **RELEASE OF SPECIAL RECORDS**

   YOU MUST PROVIDE A RESPONSE to each of the following statements in the event your record contains such information:

   a. ___I DO or ___I DO NOT authorize disclosure of substance use disorder treatment records.
   b. ___I DO or ___I DO NOT authorize disclosure of records of treatment or diagnosis of HIV or AIDS (including test results)

   Substance use disorder treatment records are protected under federal regulations governing the confidentiality of substance use disorder patient records, 42 CFR Part 2, and the Health Insurance Portability and Accessibility Act, 45 CFR Parts 160 and 164. These rules prohibit the recipient 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 law.

5. **PURPOSE FOR USE OR DISCLOSURE:** ☐Personal Use ☐Treatment ☐Legal ☐Other_____

6. **EXPIRATION:** Unless another date, event or condition is listed below, this authorization will expire one (1) year from the date it is signed. Other date, event, or condition: _____

7. I understand RiverValley may not condition treatment or eligibility for care on my providing this authorization except if such care is (1) research related, or (2) provided solely for the purpose of creating protected health information for disclosure to a third party. If I refuse to provide authorization under the aforementioned circumstances, RiverValley may refuse to provide care or treatment for these purposes.

   I understand that information disclosed by this authorization, except for substance use disorder treatment information, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 CFR Part 164) and the Privacy Act of 1974 (5 USC 552a) and I have the right to revoke this authorization at any time in writing and upon delivery to RiverValley, except to the extent that action has been taken in reliance on this authorization, or if applicable, during an insurance contestability period. I may request a copy of this form.

Client Signature: _____ **Date**_____

_____ **Date**_____

Signature of: ☐ Parent ☐ Guardian ☐ other, specify relationship: _____