



Authorization to Disclose and/or Obtain Confidential Information

I, _____ to: _____, (DOB) _____ authorize Employee & Family Resources (EFR)

_____ Disclose written and verbal information to the individual or organization identified below
 _____ Obtain written and verbal information from the individual or organization identified below

Name or Org:	Address/City/ State/Zip:
Telephone and/or Fax number:	Email:

Description of Information to be Disclosed - Client to initial each item to be disclosed

- | | | |
|--|--|--|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Presence/Participation in Treatment | <input type="checkbox"/> Demographic Information |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Medical Information | <input type="checkbox"/> Psychotherapy Notes |
| <input type="checkbox"/> Psychosocial Evaluation | <input type="checkbox"/> Discharge/Transfer Summary | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Treatment Plan or Summary | <input type="checkbox"/> Continuing Care Plan | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Current Treatment Update | <input type="checkbox"/> Progress in Treatment | _____ |

Specific authorization for release of information protected by Federal and State law (client initials required):

Mental health records Substance abuse records HIV related information


Purpose of disclosure: _____

****This authorization does not meet the criteria for the release of information for purposes of sales, marketing, or research*

Expiration: This authorization will terminate upon the earlier of twelve months from the date of this authorization, or _____
 _____ (specific date, event, or condition)

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying EFR in writing at the address provided on this form; the revocation will not apply to any information already released by EFR before receiving the revocation
- Signing this authorization is not a condition for my treatment or payment of my treatment; potential consequences for my refusal to sign this authorization, if applicable were explained to be: _____
- There is the potential that the protected health information (PHI) disclosed by EFR per this authorization may be redisclosed by the recipient and the PHI will no longer be protected by the HIPAA privacy regulations or 42CFR, Part 2 unless the recipient of the information is also obligated to and compliant with HIPAA and 42CFR, Part 2.

 _____
 Signature of Client _____
 Date

 Name & Signature of Person authorized to sign in lieu of the client, if applicable _____
 Date

Explanation of representative's authority to act for the client _____

_____ I was offered and/or given a copy of this authorization (Client and or representative initial)

NOTICE OF REDISCLOSURE

This authorization permitted information to be disclosed to you from records protected by state and federal confidentiality rules (HIPAA, 42CFR, Part 2, & Iowa chapter 228). Federal law prohibits 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 law. 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 client.