Yellowstone Counseling Center

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Authorization for Release of Protected Health Information

Client Name: _____ Date of Birth: _____

Address: _____ Phone: _____

I authorize YELLOWSTONE COUNSELING CENTER to use or disclose information from my health records, which may include information about mental health treatment and substance abuse services, to/from:

Name/Agency: _____ Phone: _____

Address: _____ Fax:_____

Information to be released (please initial):

_____Appointment Dates/Times	_____Mental Health Evaluation	_____Drug and Alcohol Testing
_____Payment/Collection Records	_____ Psychiatric Records	_____CD Evaluation
_____Progress Notes	_____ Services Provided	_____Progress/Compliance Reports
_____Entire Mental Health or CD Records	_____ Other (Please describe):_____	

Purpose of Disclosure: _____

Information may be communicated: ____In Person _____Phone _____Fax _____Mail _____Email

1. I understand that, unless withdrawn, this authorization will expire one year from the date of signature.
2. I understand that I may revoke this authorization at any time by notifying Yellowstone Counseling Center at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specifically protected information, such as substance abuse treatment information and mental health information.
4. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future services, except where disclosure of the information is necessary for the treatment.
5. I understand I have a right to a copy of this authorization.

By signing below, I acknowledge that I have read and understand this Authorization.

Signature of Patient _____ Date _____

Signature of Parent/Guardian _____ Date _____

Relationship to Patient _____

Signature of Witness _____ Date _____

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

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 42 CFR 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 persecute any alcohol or drug abuse patient. (52 FR 21809, June 9, 1987; 52 FR 41997, Nov. 2, 1987).