



**AUTHORIZATION FOR RELEASE OF INFORMATION  
HIPAA COMPLIANT RELEASE**

2011

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Release of Information **FROM:** \_\_\_\_\_

**TO:** \_\_\_\_\_

I hereby authorize and request the exchange of information (verbally or in writing) between Little Rivers Health Care and the above named individual/organization. The following information is requested to be shared:

**Those items which are pertinent to this referral**

- |  |  |
|--|--|
| <input type="checkbox"/> Office Notes      | <input type="checkbox"/> Intake Assessment                 |
| <input type="checkbox"/> Test Results      | <input type="checkbox"/> Psych/Social/Emotional Evaluation |
| <input type="checkbox"/> Medications       | <input type="checkbox"/> Treatment Plan                    |
| <input type="checkbox"/> Immunizations     | <input type="checkbox"/> Summaries                         |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Counselor Reports                 |
| <input type="checkbox"/> Teacher Reports   | <input type="checkbox"/> All                               |

Reason for Request \_\_\_\_\_

•Release of confidential information is subject to State and Federal Laws. By signing this release, I acknowledge my permission to release the above information to and/or from the individual or agency I have named which may include drug and alcohol abuse information.

*Note: Federal regulations govern the confidentiality of alcohol and drug dependent persons (42CFR Par 2). Federal Law prohibits the disclosure of (1) psychotherapy notes, (2) information compiled in reasonable anticipation, or for the use in civil, criminal, or administration action or proceedings.*

•I understand I may revoke this authorization at any time by notifying LITTLE RIVERS HEALTH CARE in writing, except to the extent that: a) action has been taken in reliance on this authorization; or, b) if this authorization is obtained as a condition or obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

•I understand I have a right to request and receive a **Notice of Privacy Practices** for LITTLE RIVERS HEALTH CARE, INC.

•All releases expire one year from the date signed unless otherwise indicated.

•I hereby authorized the following; (please initial if applicable)

\_\_\_\_\_ Disclosure of the results of HIV antibody blood testing and/or information concerning AIDS (Acquired Immune Deficiency Syndrome).

\_\_\_\_\_  
Signature of Patient or Patient's Representative

\_\_\_\_\_  
Relationship

Witness \_\_\_\_\_

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

Prohibition of Re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.