Hagan Health

Consent to Release Information

Client Name:____ DOB:______________________

I authorize:

Clinician Name:____

Phone:_________________________ Fax:_________________________

Email:____

Address:____

To release and obtain treatment information to/from the following:

Name:____

Phone:_________________________ Fax:_________________________

Email:____

Address:____

- ☐ Please check this box if you authorize the release of ALL relevant protected health information to the above person(s).
- ☐ Please check this box if you would like to limit this release to SPECIFIC relevant protected health information to the above person(s). If you check this box, please specify what health information you authorize to be released here: ____________________________

  ____

By signing below I acknowledge that the above information about me may be released, discussed, or disclosed. I understand that my records are protected under Federal Regulations governing Confidentiality of Protected Health Information (PHI) under HIPAA and Confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2 and cannot be disclosed without my consent unless otherwise provided for the regulations. I also understand that I may revoke this authorization at any time and must do so in writing and present this written revocation to my clinician. I understand that once information is disclosed as per my authorization, the recipient, in accordance with eh applicable laws and regulations, may re-disclose the information and it might not be protected by federal or state privacy regulations.

Signature of Client (or Responsible Person):____

Date Signed:__________________________

Signature of Witness:____

Printed Name of Witness:____