926 Aspen St • P.O. Box 73511 • Fairbanks, Alaska 99707
Phone (907) 451-8208 • Fax (907) 451-8207
www.hopecounselingcenter.org

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Client Name:	Date of Birth:
Address:	
Social Security Number:	

I hereby authorize **Hope Counseling Center** to:

☐ **Obtain Confidential Information From:**
☐ **Disclose Confidential Information To:**
☐ **Exchange Confidential Information With:**

Name:_____ Phone #:_____

Address:_____

Fax #:_____ Date Information Needed:_____

1. **The purpose for which this information may be disclosed:**
   - ☐ Treatment
   - ☐ Care Coordination
   - ☐ Insurance
   - ☐ Other: _____

2. **What information may be disclosed:**
   - ☐ Presence in Treatment
   - ☐ Appointment Information
   - ☐ Diagnostic Assessment
   - ☐ Diagnosis/Prognosis
   - ☐ Psychological Reports/Tests
   - ☐ Progress in Treatment
   - ☐ Discharge Summary
   - ☐ Alcohol & Drug Abuse Records (*Protected by Federal Confidentiality Rules 42 CFR Part 2 which prohibit any further disclosure unless further disclosure is expressly permitted or written authorization by the person to whom it pertains or as otherwise permitted by 42 CFR Part 2).*

3. **Requested Information from**: _____ **to**: _____

4. **This authorization expires twelve (12) months from the date of my signature below.**

5. **I understand that:**
   - the federal Privacy Rule (HIPAA) does not protect the privacy of information if re-disclosed and therefore request that all information obtained be held strictly confidential and not be further released by the recipient. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and state laws.
   - I may revoke this consent at any time by completing a written *Revocation of Release of Information Form*. Revoking this authorization does not apply to information that already has been released under this authorization.
   - I need not consent to the release of information in order to obtain services. I choose to do so willingly for the purpose(s) specified above. Treatment will still be provided to me if I do not sign this form.

_____ _____
Signature of Client or Authorized Representative Date

_____ _____ _____
Printed Name Relationship to Client Witness

SUBMIT FORM