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[www.hopecounselingcenter.org](http://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
- 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).*)
- Psychological Reports/Tests
- Progress in Treatment
- Discharge Summary

**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