Front Street Clinic

Psychiatric & Psychological Services

Consent for Release of Information and Records

CLIENT NAME (Print) ________________________________ DOB/SSN: ______________________

I understand that authorizing the disclosure of this information is voluntary. I need not to sign this form to receive treatment. I understand that I may request details of disclosures made from my records and that all disclosures require tracking, thus may not be part of the record (45 CFR Part 164). I understand that a disclosure of my information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact my provider: ____

At: P.O. Box #1611 Poulsbo, WA 98370 Ph: (360) 697-1141 Fax: (360) 697-2395

My provider, listed above, may Disclose to/ Receive information from:

Person/ Agency (use full name) ____

Address: ____

City: __________________________ State: _________ ZIP Code: ____________________________

Phone: __________________________________ Fax: _____________________________________

This authorization will remain in effect for 180 days from the date of signature or less as specified: _______________

This notice may accompany a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. 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 C.F.R. 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 prosecute any alcohol or drug abuse patient.

I understand I have the right to revoke this authorization at any time. The revocation must be in writing and presented to my provider. I also understand that the revocation will not apply to information already released in response to this authorization. I understand the revocation will not apply to circumstances where state or federal regulation require access to information for specific incidents including, but limited to, reporting incidents of abuse, neglect or domestic violence, for qualified research, audit or program evaluation, reporting to public health authority to prevent or control disease, emergency medical care, court order, or to facilitate an application or claim for public benefits.

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AUTHORIZATION FOR RELEASE OF INFORMATION – PG. 2

CONSENT OF A MINOR: A minor client's signature (ages 13 to 17) is required in order to release information concerning care for behavioral/mental health conditions and/or alcohol/drug abuse issues. A minor client's signature (ages 14 to 17) is required in order to release information concerning care for conditions relating to the minor's sexuality including, but not limited to HIV/AIDS, contraception, pregnancy and/or termination, sterilization and sexually transmitted diseases.

A COPY OR FAX SHALL BE CONSIDERED VALID IN LIEW OF ORIGINAL

I understand this disclosure may include mental health/psychiatric information. Check mark the type of information to be disclosed (include dates when appropriate- limit request to the least information necessary for your purpose, we do not send "all.")

Purpose of Disclosure: Treatment planning and continuity of care: ________________ OR________________

Psychiatric Diagnosis - Intake Evaluation	_________	Psychological History	_________
Medical – Psychological Testing Results	_________	School Records	_________
Progress Notes	_________	Drug/Alcohol Information	_________
HIV – AIDS – STD Information	_________	Termination – Treatment Summary	_________

Other (please be specific) ____

Client Signature: ____ Date: ________________

Parent/*Guardian/*Legal Representative: _______________________________ Date: ________________
(*Must have copy of court appointment of power of attorney in the chart)

Witness (if client signs with a "X": ____________________________________ Date: ________________

Renewal Signature: ____ Date: ________________

Witness (if client signs with an "X"): ___________________________________ Date: ________________