Release of Information to:
Help and Hope Counseling

PO Box 13403
Mesa, AZ 85216
Phone: 602-435-4356
Email: Dale@Help-Hope.com

Client Information: **Today's Date:** _____

First Name: _____ **Last Name:** _____

Date of Birth:_____ **Preferred Name:** _____

Name of agency/provider/person to disclose information with/from Help and Hope Counseling:

Agency Name: _____

Provider's/Person's Name: _____

Relationship to the Client:_____

Address: _____

Phone:_____**Fax Number:**_____

Please check the type of information to be disclosed:

_____ Treatment Plan
_____ Progress Notes
_____ Standard or other Diagnostic Assessments
_____ Diagnosis
_____ Medications
_____ Verbal Consult - Reciprocal
_____ Appointment scheduling (dates and times).

Reason for Disclosure: Continuity of Care

Written Revocation: I understand that I have the right to revoke this authorization at any time but must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Verbal Revocation Clause: All revocations must be in writing unless the revocation is for Substance Abuse Treatment – in which case verbal revocation is acceptable.

Re-disclosure: Notice to accompany disclosure. Each disclosure made with the patient's written consent must be accompanied by the following written statement: "This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR 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 CFR 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 that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Conditions: Signing this consent is voluntary. I understand that I will not be denied services with Help and Hope Counseling if I refuse to sign.

Today's Date: _____

This authorization will expire in: 1 year ____, 6 months____, 90 days _____
(check your selection)

_____ _____
Client or Parent/Guardian Signature **Date Signed**

_____
Printed Name of Signer

(If client is under the age of 18, I certify that I am authorized to seek medical treatment on behalf of this child.)

I received a copy of this release: Client initials _____

_____ _____
Witness Name & Relationship to Client **Date**