Authorization to Release/Obtain Information

PARTICIPANT'S NAME: _____
DATE OF BIRTH: ____/ ____ / _____
(Please print)

I hereby authorize House of Hope (see specific person/program below):

PROGRAM NAME: House of Hope Girls Program
ADDRESS: P O Box 21283, St Simons Island, GA 31522
TELEPHONE NUMBER: (912) 689-9840.

_To release the following protected information to:
AND/OR
_To obtain the following protected information from:

PERSON or AGENCY NAME: _____
ADDRESS:_____
_____
TELEPHONE NUMBER: _____

The protected health information authorized to be obtained/used or disclosed includes:

Demographic information of client, medical records, psychological evaluations, medication records, treatment plans, admissions packet, health insurance information, placement into House of Hope's Girls Residential Program, any transition/discharge plans.

The protected health information is to be obtained/used or disclosed for the purpose of:
Coordination and continuation of care of the referred client.

RESTRICTIONS (please tell us what you would *not* like given out):

This Authorization is in effect until:

_the period necessary to complete all transactions on matters related to services provided to me.
_one year from the date this form is signed ____/ ____ / _____

I understand that the federal Privacy Rule (HIPAA) does not protect the privacy of information redisclosed, and, therefore, request that all information obtained from this person or agency be held strictly confidential and not be further released. I further understand that my eligibility for benefits, treatment or payment is not conditioned upon my provision of this authorization.
I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand I have the right to revoke this authorization, in writing, at any time.

Signature of Applicant/Guardian/Participant_____Date: _____

Signature of Witness/Title_____ Date: _____

Use this space only if individual withdraws authorization

Date authorization is withdrawn_____ Signature of Individual_____

Printed name of Individual _____

Reason for withdrawal: