CONSENT TO RELEASE/EXCHANGE INFORMATION

_____ _____ _____
Name of Client Birth Date Insurance and #

I, the undersigned, authorize the following provider/agency:

Provider/Agency releasing information: _____

_____
Address City State Zip Phone

to release/disclose information regarding my treatment, including but not limited to copies of my records to the following:

Provider/Agency receiving information: _____

_____
Address City State Zip Phone

NOTE; NEVADA STATE LAW STATES THAT WE MAY CHARGE $0.60 PER PAGE TO COPY PATIENT'S RECORDS

Information to be released (Check all that apply):

_____ Psychiatric History
_____ Medical History
_____ Laboratory Reports
_____ Progress Notes
_____ Other (Specify) _____

The purpose for which the information is to be used is:

_____ Continuity of Care
_____ Diagnosis and Treatment
_____ Other (Specify) _____
_____ Insurance payment
_____ Coordination of Care/Treatment

I understand that my records are protected under Federal (42 CFR Part 2), Health Insurance Portability and Accountability Act of 1996 and State Confidentiality Regulations. This authorization is valid only for release of information to the above named provider/agency. This authorization shall be valid for a period of 90 days unless revoked in writing by the under-signed or authorized representative, except to the extent that action has been taken in reliance hereon. File copy is considered equivalent to the original. I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

_____ _____
Client Signature Date Witness Date
(If minor, must be signed by Parent/Guardian)

NOTARY SEAL

Print Name of Parent/Guardian/
Authorized Representative: _____

NOTICE TO RECIPIENT: PROHIBITION OF RE-DISCLOSURE
If these records contain information relating to alcohol and/or drug abuse treatment records, then the following applies to your use of this information:

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.

Exclusion: I have reviewed the above release of information form with the patient and discussed the importance of coordinating care between mental health and medical care providers. The patient has refused to authorize release of mental health and/or alcohol or drug abuse treatment records.

Signature of Provider: _____ Date: _____