AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

_____ _____ _____
Client Name Date of Birth Medical Record No.

_____
Client Address City State Zip Code

Aspire is authorized to: release and/or receive the content of my Medical Record indicated below, including any content relating to drug and alcohol use or treatment, infectious disease including HIV/AIDS, and/or any other personal information generated by my assessment and treatment to/from the person/organization listed below.

The content of my record can be released through any appropriate HIPAA compliant channels to/from:

*Authorize to:

____Release ____Receive

_____ _____
Name/Organization/Relationship Phone

_____
Address City State Zip Code

Specify Dates of Records Requested

_____ _____
Starting Date Ending Date

*Purpose of the Disclosure (Select all that Apply, **Must Select One**):

____Evaluation ____Court Evaluation ____Insurance Claim ____Continuity of Care ____Client Request ____Collabortion with School ____Other

*Specific Description of Information to be Released (Select all that apply, **Must Select One**):

____Standard Documentation Set. Includes most recent treatment plan, diagnosis, and summary update; comprehensive assessments; Psychiatric evaluations; substance abuse evaluations; therapy notes; medication reviews; progress reports; termination summaries

____Evaluations/Assessments ____Treatment Plans ____Progress Notes ____Medication Notes/Labs ____Probation Reports/Drug Screen Result ____Medical Office Records ____Other

I understand that I may request that specific information be excluded from this release, recognizing that doing so may invalidate the entire release if withholding the information may present an inaccurate description of a condition and/or associated treatment.

Specific Information to be **EXCLUDED** from this Authorization, If Any:

____Drug and Alcohol Records ____HIV/AIDS Records ____Infectious Disease Records

- I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations.
- I understand that I may revoke this authorization by notifying Aspire, 2020 Brown Street, Anderson, IN 46016, orally or in writing (persons being seen for drug/alcohol treatment may make an oral request) of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on previous action taken by Aspire in reliance upon this authorization.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Aspire.
- I understand that this authorization may be utilized electronically by Aspire and its agents.
- This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR Part 2) and HIPAA Privacy Regulations. 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.

Patient Acknowledge and Confirmation

*Please select **ONE** option **only:**

____I understand this authorization expires in 180 days

____I understand this authorization expires on the happening of the following event/date (within 180 days)

Please specify the date / event set to occur within 180 days *

_____

____Waive - I understand my records are protected under State and Federal confidentiality laws and HIPAA Privacy Regulations and this consent would normally expire by law after a period of 180 days; however, I expressly waive the 180 day limitation and consent to disclose and exchange information with the above entity until 60 days after termination of Aspire services unless sooner specifically revoked by me orally or in writing

_____
Signature of Patient

_____ _____
Parent/Legal Guardian Date

- A faxed, scanned, electronic or photocopied presentation of this authorization is as valid as the original
- Unless otherwise noted, send requested information to: Aspire, Medical Records Department, 2020 Brown Street, Anderson, IN 46016