RELEASE OF INFORMATION AUTHORIZATION

U.S. CARE BEHAVIORAL HEALTH

Client Name: _____ **Date of Birth:** _____

I authorize U.S. Care to release and disclose to the following and for the following to release and disclose information to U.S. Care:

Name, phone, and fax number of person or organization to receive information from U.S. Care and/or send information to U.S. Care:

Person's Name: _____

Organization's Name: _____

Phone Number: _____ **Fax Number:** _____

Information to be released and disclosed:

☒ Admission History ☒ Medical/Physical Evaluation ☒ Psychological Evaluation

☒ Discharge Summary ☒ Progress Notes ☒ Substance Abuse Treatment

☒ Medication Records ☒ Psychiatric Evaluation ☐ Other: _____

Purpose:

☒ Assessment/Evaluation ☒ Discharge Planning ☒ Treatment/Service

☐ Other: _____

This authorization expires in one year, unless otherwise stated here: _____

Federal Law protects the confidential information that has been disclosed to you. Federal regulation (42 CFR part 2) prohibits you from making any further disclosures of the Information without the direct consent of the individual or legal guardian, or as otherwise permitted by such regulations.

As the individual signing this authorization, I give permission for U.S. Care to use, disclose and/or request health care records until this authorization expires. I also understand that this consent may be canceled at any time except for information already released in accordance with this authorization. In addition, I understand that to cancel this authorization, I must request such in writing.

_____ _____

Client Signature **Date**

_____ _____

Parent/Guardian Signature **Date**