



AUTHORIZATION TO RELEASE INFORMATION



(Please check one)

Community Reach Center

Mountainland Pediatrics, Inc.

Client Name: _____

ID: _____

DOB: _____

Origin of Authorization: External Internal (Reach Center or Pediatrics)

Direction of Authorization: Outgoing Incoming

I hereby authorize (Information Source Agency): _____

to release the following information (Information to Release):

- | | | |
|--|---|---|
| <input type="checkbox"/> Intake/Initial Assessment | <input type="checkbox"/> Psychological Evals/Reports | <input type="checkbox"/> Treatment Plan |
| <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Monthly Summary | <input type="checkbox"/> HIV Status |
| <input type="checkbox"/> Social History | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> CCAR |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Progress Summary | <input type="checkbox"/> Medical Evaluation |
| <input type="checkbox"/> Psychiatric Eval/Notes | <input type="checkbox"/> Drug/Alcohol History/Treatment | <input type="checkbox"/> Claims/Billing Information |
| <input type="checkbox"/> Other _____ | | |

The information will be disclosed to (Information Destination Agency): _____

for the purpose of (Reasons for Release):

- | | | |
|--|---|--|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Service Planning | <input type="checkbox"/> Coordination/Continuity of Care |
| <input type="checkbox"/> Benefits Coordination/Acquisition | <input type="checkbox"/> Legal Purposes | <input type="checkbox"/> Payment of Insurance Claims |
| <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Referral | |
| <input type="checkbox"/> Other: _____ | | |

Expiration Date: _____ (One year from creation, unless otherwise specified)

I understand Community Reach Center and/or Mountainland Pediatrics cannot condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form or not. If the information authorized to be released pertains to diagnosis and treatment of alcohol and/or drug abuse, I understand the information is protected by Federal Law 42, C.F.R. Part 2. I understand that there is potential for information disclosed, disclosed as a result of this authorization, to be re-disclosed by the recipient and therefore no longer protected by the HIPAA Privacy Regulation. I understand that I may revoke this authorization at any time by giving written notice to Community Reach Center and/or Mountainland Pediatrics, except to the extent that action has already been taken to comply with it. Without such revocation, this authorization will expire one year from the date of my signature unless otherwise requested at the onset of this authorization. I understand that I have a right to refuse to sign this form subject to the conditions noted above. If I sign the form, I am entitled to a copy of that signed form.

Signature: _____

Signed by (print name): _____

Relationship to Client: _____

Authority to Sign: _____

Date Signed: _____

Witness Signature: _____

Witnessed by (print name): _____

Date Signed: _____