THE Alpha Center
NOURISHING THE MIND
BODY & SPIRIT

AUTHRORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient's Name: _____
Last First Middle

Social Security Number: _____ Date of Birth: _____

Home Address: _____
Street City State Zip Code

Home Phone: (_____) _____ Cell Phone: (_____) _____

I hereby authorize The Alpha Center to release my confidential health information to the following Designee:
(This Section must be complete for the release to be valid. Records will be sent only to the address/fax number provided on this release.)

Recipient: Name/Agency: _____ Attention: _____
Address: _____ Suite: _____
City, State, Zip: _____
Phone: (___) _____ Fax: (_____) _____

I authorize the following information to be released: (please check all that apply)

_____ All Treatment Records for specified dates of treatment as follows: _____
_____ Outpatient Counseling Attendance Letter (includes admission/discharge dates and discharge status)
_____ Program Attendance Letter (includes admission/discharge dates and discharge status)
_____ Continuing Care Group Attendance
_____ Discharge Summary
_____ Continuing Care Plan
_____ Laboratory/Radiology Reports (includes Drug Screen, EKG, SPECT, MRI/PET/CT, and other test results)
_____ Assessments (may include History and Physical, Biopsychosocial Assessment, Diagnostic Summary)
_____ Psychiatric/Psychological Assessments and testing (includes Psychiatric Evaluation or other personality/mental health testing)
_____ Treatment Plan and Reviews
_____ Progress Notes (includes Physician, Clinical and Nursing)
_____ Medications and other Physician Orders
_____ Other: _____

Description of the purpose for the disclosure: (check one)
_____ Continuum of Care _____ Personal Use _____ Legal _____ Other: _____

Disclaimer: I understand that information to be used or disclosed pursuant to this authorization form may include information relating to: (1) acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection; (2) treatment for drug and/or alcohol abuse; and/or (3) mental or behavioral health or psychiatric care, 42 CFR Part 2: 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 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.

Conditions: Alpha Counseling Center will not condition my treatment on whether I give authorization for the requested disclosure. I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and to the best of my knowledge.

Re-disclosure: Federal law prohibits the person or organization to which disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by written authorization of the person to whom it pertains or as otherwise permitted or required by law.

Revocation: I, the undersigned, I understand that I may revoke this authorization at any time by notifying Alpha Counseling Center in writing, except to the extent that action has been taken in reliance thereon. I further understand and agree that this consent may not be verbally withdrawn.

Photocopy: A photocopy of this authorization is valid as an original.

Notification: I have the right to receive a copy of this authorization. The copy is for me.

Expiration: This authorization will expire 180 days from the date of my signature or as otherwise specified as follows: _____

_____ _____
Patient Signature/or Personal Representative Date

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