metrocare.

OFFICE USE ONLY:

☐ Photo ID ☐ Signature Verified ☐ Other: _____

Staff Name:_____

Staff Signature:_____

AUTHORIZATION FOR RELEASE OF INFORMATION

Disclosure: Metrocare will not condition treatment, payment, enrollment, or eligibility for benefits based on the completion of this form.

This authorization is intended to allow METROCARE SERVICES to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure. I reserve the right to remove this authorization at any time by providing written notice of removal to Metrocare for the named individual/facility. The removal will be effective as of the date it is received except to the extent Metrocare has already relied upon my authorization to use or disclose my health information as described in the Notice of Privacy Practices.

SECTION I - CLIENT DATA

1. NAME: *(First, Middle, Last Name)*	2. DATE OF BIRTH: *(MM/DD/YY)*	3. SOCIAL SECURITY NUMBER:
4. EMAIL:	5. PHONE NUMBER: *(XXX) XXX-XXXX*	6. MRN: *(Medical Record Number)*

SECTION II - DISCLOSURE

7. I hereby authorize Metrocare to disclose/use/receive the specified protected health information below from the medical record of the above-named individual. **The designated staff may ☐ disclose to *OR* ☐ receive from, the following organization or person:**

a. NAME OF FACILITY *OR* PERSON:	b. ADDRESS *(Street, City, State and ZIP Code)* *or* Email:
c. TELEPHONE: (Include Area Code)	d. FAX: (Include Area Code)
8. TYPE OF INFORMATION: ☐ Mental Health Records ☐ Primary Care Records ☐ Cohen Records	*9. PERIOD OF TREATMENT:* *(MM/DD/YY)* FROM: TO: OR ☐ ***ALL RECORDS***

10. PURPOSE OF DISCLOSURE:

☐ Personal Use ☐ Treatment/Continuing Care ☐ Attorney/Legal ☐ Educational Use
☐ Discuss w/ Family ☐ Disability ☐ Housing ☐ Other (*specify*): _____

11. INFORMATION TO BE RELEASED

☐ Psychiatric Evaluation ☐ HIV/AIDS Results ☐ Provider Notes ☐ Sexual Transmitted Disease (STD) Results
☐ Psychological Evaluation ☐ Medication List ☐ Labs ☐ Other (*specify*): _____
☐ Progress Notes ☐ Diagnosis Letter ☐ Treatment Plans

12. ☐ I authorize the release of the selected information **including** all records that include any substance use disorder and/ or substance use disorder treatment records, or

☐ I authorize the release of the selected information **excluding** all records that include any substance use disorder and/or substance use disorder treatment records.

SECTION III - EFFECTIVE TIME PERIOD

13. This authorization is valid for 1 year from the date it is signed, or on _____. If no date is specified, this authorization will expire one (1) year from the date of signature.

SECTION IV - SIGNATURES

14. INDIVIDUAL SERVED: (Print)	15. SIGNATURE: *DATE: (MM/DD/YY)*
16. LEGALLY AUTHORIZED REPRESENATIVE: (Print) RELATIONSHIP:	17. SIGNATURE: *DATE: (MM/DD/YY)*