

**Client Authorization to Release Information**

\_\_\_\_\_  \_\_\_\_\_  \_\_\_\_\_  
Name of Patient/Client Date of birth Social Security Number

I, the undersigned, authorize the following provider/agency **Jewish Family Service Agency, 4794 S. Eastern Ave, Suite C Las Vegas, NV 89119** to release/exchange information regarding my treatment, including, but not limited to copies of my records to the following:

Individual/Provider/Agency: \_\_\_\_\_

Address City State Zip Phone

**Information to be released (Check all that apply):**

Psychiatric History  Case Management Notes  Medical History  
 Psychiatric Progress Notes  Drug/Alcohol History  Other: \_\_\_\_\_

**The purpose for which the information is to be used is (Check all that apply):**

Continuity of Care  Case Management \_\_\_\_\_ Insurance Payment  
\_\_\_\_\_ Diagnosis and Treatment  Coordination of Volunteer Services  
\_\_\_\_\_ Drug/Alcohol Treatment \_\_\_\_\_ Other: \_\_\_\_\_

I understand that my records are protected under Federal (42 CFR part 2) Health Insurance Portability and Accountability Act of 1996 and State Confidentiality Regulations. This authorization is valid only for release of information to the above named provider/agency. This authorization shall be valid for a period of 120 days unless revoked in writing by the undersigned or authorized representative, except to the extent that action has been taken in reliance hereon. File copy is considered equivalent to the original. I further acknowledge that the information released was fully explained to me and this consent is given of my own free will.

X \_\_\_\_\_  
Patient/Client Date Witness Date

Parent/Guardian or Authorized Representative: \_\_\_\_\_

**NOTICE TO RECIPIENT: PROHIBITION OF REDISCLOSURE**

If these records contain information relating to alcohol and/or drug abuse treatment records, then the following applies to your use of this information:

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 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.

I have reviewed the above release of information form with the patient/client and discussed the importance of coordinating care between mental health and medical care providers. The patient/client has refused to authorize release of mental health and/or alcohol or drug abuse treatment records.

Provider Date Patient/Client Date