NorthKey Community Care

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ (S.S. No./I.D. No.) _____ (Date of Birth)
(Full Name of Client)

authorize and give this consent voluntarily. I have been informed of the specific type of information that has been requested and the benefits and disadvantages of releasing information that has been explained to me. I also understand that the provision of services is not contingent on my decision concerning this release of information.

(check appropriate box(s): (Complete Left to Right)

☐ FROM (List address of office)

NorthKey Community Care

☐ TO (Full name and address of individual/agency)

☐ TO

NorthKey Community Care

☐ FROM (Full name and address of individual/agency)

TYPE OF INFORMATION TO BE RELEASED: (Check all that apply)

___ Admission Summary
___ Psychiatric Eval.
___ Psychological Eval.
___ Current Medical Status
___ Other (Specify)_____
___ Progress Notes
___ Treatment Plans
___ Laboratory Tests
___ Discharge Summary
___ Treatment Information which may include Human Immunodeficiency Virus (HIV) Infection, Acquired Immunodeficiency Syndrome (AIDS) Or Tests For HIV.
___ Drug, Alcohol Assessments
___ Drug, Alcohol Treatment Notes

AMOUNT OF INFORMATION TO BE RELEASED:

___ Information covering the most recent admission
___ Information covering the previous three months
___ Information from beginning to present
___ Other time frames (specify)_____

PURPOSE FOR RELEASE:

___ Report client progress
___ To obtain collateral information in treatment of this client.
___ Verify client attendance
___ Other (Specify)_____

TIME LIMITATION OF RELEASE: This authorization expires in 60 days or_____

« « « « « « » » » » » »

PROHIBITION ON REDISCLOSURE:

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by Federal Regulations. The 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.

« « « « « « » » » » » »

_____ Date
Signature of Client

_____ Date
Signature of Client's Parent/Legal Guardian

_____ Date
Witness

« « « « « « » » » » » »

REVOCATION OF RELEASE:

This release is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it.

_____ Date Revoked
Signature of client, parent, guardian

**********FOR OFFICE USE ONLY**********

(Must be completed if information released)

Specific information released:_____

_____ Date information was released:
Signature of staff releasing information:

NKCC-125
Revised 04/03