CENTERSTONE

AUTHORIZATION FOR RELEASE OF INFORMATION

Name _____ **DOB** _____ **Social Security #** _____

Client ID# _____

I hereby authorize the release of the following specific information: (Check all items)

YES	NO		
___	___	1.	Medical History, examinations, laboratory tests and treatment reports.
___	___	2.	Psychological test/psychiatric evaluation/neurological workup.
___	___	3.	Social history, including family, education, employment, arrest and drug use information.
___	___	4.	Summary of previous mental health treatment.
___	___	5.	Periodic reports of current treatment progress including attendance, participation and urine surveillance results.
___	___	6.	Other (Specify) _____

Treatment Dates to Release: ☐Any and All Records ☐Date Range: From:_____To:_____

From/To:_____
(Name & Address of Centerstone site)
From/To:_____

I understand that this information will be used for the following specific purposes: (Check Yes or No)

YES	NO		
___	___	1.	To develop a diagnosis, treatment and rehabilitation plan.
___	___	2.	To coordinate medical, psychological and social rehabilitative process.
___	___	3.	To determine present and future eligibility for probation, parole, bail bond, pre-trial release or other diversion process within the criminal justice system.
___	___	4.	To process insurance claims for services provided (diagnosis, number of visits, modalities, and expected length of treatment.)
___	___	5.	Other (Specify if yes is checked)_____

I understand that this information will not be disclosed to any other agency or individual without my written authorization, except as allowed by law. I also understand that my protected health information, which is disclosed with this release, may be subject to re-disclosure by the recipient and no longer protected by law. Centerstone is not responsible for any alterations made on its medical record copies, which have been released to any party.

I understand that I have a right to a copy of this authorization after I sign it.

I understand that Centerstone will not condition any provision of treatment on my signing this authorization.

This authorization automatically expires 1 year after the date that I sign it. I understand that this authorization may be revoked at any time with my written statement.

This authorization for **Release of Information** is given freely, voluntarily and without coercion.

_____ _____

Signature of Client **Date** **Witness** **Date**

Signature of person authorized to sign in lieu of client: _____

Guardian/Conservator **Date**

Revised: August 13, 2009