**Request/ Authorization to Release Confidential Records and Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Soc. Sec.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CIRCLE THE APPROPRIATE SELECTION:

I authorize, the Pure Hope Foundation to obtain information from:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Provider/ Facility Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip Phone Fax

PURPOSE OF THIS REQUEST

* Intake application review
* Treatment Planning

These records concern the time between \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SPECIFIC INFORMATION AUTHORIZED:

* Progress Notes
* Treatment Plans/ Summary
* Test Results
* Mental Health Evaluation
* Psychological and/or Neuropsychological Assessment Report
* Minute Orders

HIV-RELATED INFORMATION AND DRUG/ALCOHOL INFORMATION contained in these records will NOT be released unless indicated here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have had explained to me and fully understand this request/authorization to release records, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is voluntary on my part. I understand that no services will be denied me/the patient solely because I refuse to consent to this release of information, and that I am not in any way obligated to release these records. The information disclosed may be used in connection with my/the patient’s treatment. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will be valid no longer than is reasonably necessary to meet the purposes stated above, and not to exceed 1 year. If the person/organization that receives this information is not a health care provider/health insurer, the information may no longer be protected by federal privacy regulations. I also understand that I am entitled to a copy of this authorization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Resident Name of Resident Date