

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ hereby give consent and authorize No Longer Alone Ministries to receive and/or disclose information from my records related to my identity, diagnosis, prognosis and treatment with:

Name: _____

Address: _____

Phone #: _____

I understand that these record(s) may contain information regarding my psychiatric/psychological status, drug/alcohol information and/or information regarding AIDS/HIV. This information will be handled confidentially in compliance with the Mental Health Procedures Act (55PA.Code 5100), HIV (AIDS) Related Information Act 148, Federal Alcohol and Drug Abuse Act (PL92-282), Pennsylvania Drug and Alcohol Act (PL221-63) and Health Insurance Portability and Accountability Act of 1996. I understand the nature of this release and that I have the right to inspect material that is to be released.

The specific information to be received and/or disclosed includes:

Receive	Disclose		Receive	Disclose	
___	___	Discharge Summary	___	___	Initial Evaluation/Admission Note
___	___	Treatment Plan	___	___	Psychological Evaluation/Summary
___	___	Social History	___	___	Referral Information
___	___	Lab Reports	___	___	Psychiatric Evaluation/Summary/Update
___	___	History & Physical	___	___	Alcohol & Other Drug Consult
___	___	Outpatient Treatment Summary	___	___	Verbal Communication
___	___	Other (list specific items): _____			

I understand this information is to be used for the purpose of: _____.

This authorization is effective immediately and will expire in one year or on _____ for all records generated during this time period.

I understand that I may revoke this authorization at any time by giving written notice to No Longer Alone Ministries Privacy Officer. I understand that a full description of the rights that I may have in regard to this authorization can be found in No Longer Alone Ministries Notice of Privacy Practices.

This authorization shall operate as a complete release of liability of No Longer Alone Ministries, its trustees, officers, agents, and employees for the release of information as specified above. Once No Longer Alone Ministries discloses information on the basis of this authorization, we have no control over the recipient's use of the information.

Client Signature

Date

Witness Signature

Date

COMPLETE WHEN CLIENT IS UNABLE TO GIVE WRITTEN CONSENT

We, the undersigned, verify that the above authorization has been read to the client and he/she understand the nature of the release and freely give verbal consent for the release of the above information. The client has been informed that he/she may verbally revoke this authorization at any time.

Witness Signature

Date

Witness Signature

Date