emerge
counseling ministries

Authorization for Release of Information

1. Client/Patient Name:_____

2. Client Date of Birth:_____

3. Date(s) of service (Month, Day & Year to the best of your knowledge): _____

4. I authorize Emerge Counseling Ministries to: **[check the desired option(s) below]**

☐ Disclose the following information in verbal and/or written form to:
☐ Receive the following information in verbal and/or written form from:

_____
Individual or Organization

_____
Address City State/Zip

(____)_____-_____(____)_____-_____
Phone # Fax #

5. **Specific information to be released** (Initial next to all that apply):

____ History & Physical Exam
____ Diagnosis/Mental Status Exams
____ Treatment Plan
____ Progress Notes/Reports
____ Treatment Summary/Discharge Plan
____ Other (specify): _____
____ 3rd Party Correspondence
____ Consent for Treatment
____ Custody/Parenting Documentation
____ Correspondence with Attorneys/GAL/Courts
____ PHI (Including name & other identifying info.)

6. Reason for disclosure: ☐ At the request of the client ☐ Coordination of Care ☐ Other:_____

7. I understand that I may revoke this authorization at any time in writing except to the extent that action has been taken in reliance thereon. **This authorization (unless revoked) expires one year from the date provided below.** Your healthcare or payment for care will not be affected by whether you sign this authorization. A photocopy or facsimile of this authorization will have the same authority as the original.

Signature: _____ Date: _____
(Patient/Parent/Legal Guardian)

Witness Signature:_____Date: _____

This information has been disclosed to you from records protected by Federal Confidentiality rule. 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 information to criminally investigate or prosecute any alcohol or drug abuse client.

Revocation of Release of Information:

I hereby withdraw my consent for this release of information:

Signature: _____ Date: _____
(Patient/Parent/Legal Guardian)

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