emerge
counseling ministries

Authorization for Release of Information

1. **Client/Patient Name:**
2. **Client/Patient Date of Birth:**
3. **Dates of Service:** ***Circle and complete either A or B***

A	All dates of service	
B	From:	To:

4. **I authorize Emerge Counseling Ministries to:** ***(CHECK ONE OR BOTH)***

☐ 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:

Phone: **Fax:** **Email:**

5. **Specific information to be released:** ***INITIAL*** **next to** ***EACH*** **that applies:**

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

6. **Reason for disclosure:** ☐ Client's request ☐ 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 expires one date from the date below 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 (patient/parent/legal guardian): **Date:**

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 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 (sign ONLY if you're revoking the above consent):

I hereby withdraw my consent for this release of information:

Signature (patient/parent/legal guardian): Date: