CHANGE INC.

Release of Information

Date: ____/_____/_____ Client Name: _____ DOB: ____/_____/_____ Client #:_____

I give Change Inc. permission to ☐ Obtain ☐ Release ☐ Exchange professional information with:

Name of Agency: _____ Name of Person: _____

Number and Street: _____ City, State, Zip: _____

The following information to be:

- ❑ Summary of client's record
- ❑ Medical Records
- ❑ Psychological test results
- ❑ Cultural evaluation
- ❑ Treatment plan
- ❑ Progress notes
- ❑ Discharge Summary
- ❑ On-going consultation
- ❑ Diagnostic Assessment/Diagnosis
- ❑ IEP, evaluations, and progress updates/grades
- ☐ Rx prescribed
- ❑ Psychosocial family history
- ❑ Psychiatric evaluation
- ❑ Rule 25/Drug abuse evaluation
- ❑ Probation order & PSI
- ❑ Student records: Attendance, removals and suspensions, enrollment/schedule, special status and other educational data

❑ Other

Comments:_____

_____

Patient Restrictions on Methods for Disclosure: _____

I understand that communication of the items can occur:

❑ Verbally ❑ In person conference ❑ Written questionnaire ❑ Mailed or faxed medical record / correspondence

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(continued from previous page)

I understand that:

* My health information is protected by federal regulation (Alcohol and Drug Abuse Patient Records, 42 CFR Part 2: and/or HIPAA 45 CFR) and state privacy laws, and disclosure is allowed only with my authorization except in limited circumstances described in Change Inc.'s Privacy Notice. I understand that I have a right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws.

* I can revoke this authorization at any time except to the extent that action has been taken in reliance on it. Change Inc. Privacy Notice outlines the procedure for revocation. This authorization will expire in one year from the date I sign or unless I request an earlier expiration in writing.

* For disclosures other than for treatment, payment and healthcare operations purposes, treatment may not be conditioned on my agreement to sign and authorization (unless I am receiving care solely to create protected health information for disclosure to a third party) (45 CFR & 164.508 (b)(4)(III)

* Communications resulting from this authorization will reveal that I receive services at Change Inc.

* Federal confidentiality regulations (at 42 CFR Part 2) prohibit re-disclosure of information from alcohol and drug abuse patient records. However, HIPAA requires Change Inc. to notify me of the potential that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by HIPAA rules.

* This authorization may be used by Change Inc. owned or managed programs upon transfer of my care to them.

Expiration Date: _____/_____/_____ (one year from date of signature)

_____ _____/_____/_____
Client Signature Date

_____ _____/_____/_____
Parent/Guardian Signature Date

_____ _____
Change Inc. Programs Staff Name Phone Number

_____ _____/_____/_____
Change Inc. Staff Signature Date

** Information to be disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). 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 the information to criminally investigate or prosecute any alcohol or drug abuse patient.