AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH INFORMATION

I hereby authorize release of my confidential health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Client name(s):_____Phone: (_____)_____-_____

Provider or Facility providing the information:

George Stahnke

4585 Hilton Parkway, Suite 202

Colorado Springs, CO 80907

Phone: 719-287-8023 Fax:866-514-5653

Email: george@renewalcs.org

Persons/organizations receiving the information:

Name: _____

Address: _____

City, State, Zip: _____

Phone: (_____)_____-_____Fax: (_____)_____-_____

Email: _____

Description of specific information to be disclosed (including dates of service): _____

_____

_____

Does this include authorization to release drug or alcohol abuse treatment records? Yes_____No_____(initials)

Does this include authorization to release psychotherapy notes? Yes_____No_____(initials)

The release of information is being made:

❒ At the request of the individual

❒ If at the request of another, explain the purpose of the request: _____

_____

This authorization will expire on_____/_____/_____(DD/MM/YYYY)

Carefully read the following statements before signing this authorization:

1. I may revoke this authorization at any time in writing, except as to information released before receipt of the revocation.
2. I understand that my health care will not be denied if I refuse to sign this authorization.
3. Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer subject to privacy protections.
4. I am entitled to a copy of this authorization.

_____ _____ _____/_____/_____

Signature(s) of Client or Client's representative *(Form MUST be completed before signing)* Date (DD/MM/YYYY)

Printed name of Client's representative: _____

What is the representative's authority to act on behalf of the Client? _____

Note: Remember to ask for permission to release information to any key person who has worked with the patient and family (i.e. probation officer, hospital clinician, private practice clinician, teacher, guidance counselor, attorney, etc.)

As required by Section 2.32(a) PROHIBITION ON DISCLOSURE –rule: "This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose."

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION