TRANSITIONS INCORPORATED

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, _____, _____
(Full Names of Client) (SS# or I.D. #) (Date of Birth)

authorize and give this consent voluntarily. I have been informed of the specific type of information that has been requested and the benefits and disadvantages of releasing information that has been explained to me. I also understand that the provision of services is not contingent on my decision concerning this release of information.

□ **FROM** (List address of office)

Transitions, Inc.

313 Madison Pike, Erlanger, KY 41017

859-491-4435 Fax: 859-491-6598

□ **TO** (Full name, address and phone # of individual/agency)

_____

_____

_____

□ **TO**

Transitions, Inc.

313 Madison Pike, Erlanger, KY 41017

859-491-4435 Fax: 859-491-6598

□ **FROM** (Full name, address & phone # of individual/agency)

_____

_____

_____

TYPE OF INFORMATION TO BE RELEASED: **(Check all that apply)**

____ Admission Summary
____ Psychiatric Evaluation
____ Psychological Evaluation
____ Current Medical Status
____ Other (Specify) _____
_____ Progress Notes
_____ Treatment Plans
_____ Laboratory Tests
_____ Discharge Summary
_____Treatment information which may indicate Human Virus (HIV) infection, Acquired immunodeficiency Syndrome (AIDS), or Tests for HIV.
_____ Drug Alcohol Assessments
_____ Drug Alcohol Treatment Notes

AMOUNT OF INFORMATION TO BE RELEASED:

___ Information covering the most recent admission
___ Information covering the previous three months
___ Information from beginning to present
___ Other time frames (specify) _____

PURPOSE FOR RELEASE:

_____ Report client progress
_____ To obtain collateral info in treatment of this client
_____ Verify client attendance
_____ Other (Specify)_____

TIME LIMITATION OF RELEASE: This Authorization expires in 90 days or _____.

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PROHIBITION ON REDISCLOSURE

This information has been 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 information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 2.12(c)(5) and 2.65.

_____ _____
Signature of Client Date

_____ _____
Signature of Client's Parent/Legal Guardian Date

_____ _____
Witness Date

…….

REVOCATION OF RELEASE:

This Release is subject to revocation at any time, except to the extent that the program which is to make the disclosure has already taken action in reliance on it.

_____ _____
Signature of Client, (Parent/Guardian) Date Revoked