AMHC AUTHORIZATION FOR RELEASING/OBTAINING INFORMATION

I agree to allow AMHC to: **RELEASE TO:** ☐ **OBTAIN FROM:** ☐ **(CHECK THE APPROPRIATE BOX(es)**

(Full name of person or organization authorized to receive/release information)

Address — Phone (if available)

Relationship to Client

The specific information / material to be released is:

- ☐ Assessment & Evaluation Information
- ☐ Psycho-Social History
- ☐ Treatment Plan/Reviews
- ☐ Psychological Reports
- ☐ Psychiatric Evaluation
- ☐ Discharge Planning
- ☐ Crisis Plan
- ☐ Substance Abuse Information
- ☐ Medical History/Physical
- ☐ Medication Reports
- ☐ Progress Notes
- ☐ Vocational Information
- ☐ Academic Records
- ☐ Financial Information
- ☐ Disability Determination Report
- ☐ Other: ____

The information is to be used to:

- ☐ Verification of Services
- ☐ Service Coordination
- ☐ Legal Matters
- ☐ Discharge/Aftercare Planning
- ☐ Treatment/Service Planning
- ☐ Follow-up
- ☐ Laboratory/X-Ray Results
- ☐ Other: ____

This authorization for releasing/obtaining the above information is to be in effect through ____ unless otherwise revoked.
(not to exceed 6 months for children and 12 months for adults)

I understand that my health care provider(s) need my specific consent to disclose information related to any of the following. Such information may not be redisclosed by the recipient without my specific written consent.

1. **Substance Abuse Treatment:** I (☐ DO / ☐ DO NOT) authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse.
2. **Mental Health Records:**
   ☆ I (☐ DO / ☐ DO NOT) authorize disclosure of information which refers to treatment or diagnosis of mental health.
   ☆ I (☐ DO / ☐ DO NOT) want to review such information before it is released. I understand that such reviews must be supervised.
3. **HIV Records:** I (☐ DO / ☐ DO NOT) authorize disclosure of information which refers to HIV test results, infection status, or treatment information.

☆ I understand that I have the right to:

- Obtain a copy of this authorization, and to review and copy any information prior to it being released.
- Review my records and refuse authorization to disclose all or some of the information.
- Revoke this authorization by written notice to the health care provider at any time, except where the health care provider has already acted upon the authorization. (See exception to this Right in the Notice of Privacy Practices in the Client Handbook given to you at intake).

☆ I understand that such refusal or revocation may result in improper diagnosis or treatment, denial of coverage or benefits or other insurance or other adverse consequences.

☆ I further understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient. In the event the information is further disclosed by the receiving party, it may not be protected under federal privacy regulations.

X

Client Signature — Date

Signature of Authorized Person — Basis for Authorization (Relationship to Client) — Date

I hereby **revoke this Authorization** for the releasing/obtaining of information.

Client Signature — Date

Signature of Authorized Person — Basis for Authorization (Relationship to Client) — Date

CLIENT NAME: ____ **DATE OF BIRTH:** ____ **CLIENT #:** ____