



Renewed Hope Counseling and Wellness

1550 N Crestmont Dr. Suite A, Meridian, ID 83642

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Release of Information – Clinic

Patient Name: _____

Date of Birth: ___/___/___

I authorize Renewed Hope Counseling and Wellness to release information to/from:

Agency Name: _____

Phone: _____

INFORMATION THAT MAY BE RELEASED

(please check all that apply)

Mental Health/physical Information:		<input type="checkbox"/> Presence and Progress in Treatment
<input type="checkbox"/> Assessments	<input type="checkbox"/> Psychiatric Summary	<input type="checkbox"/> Diagnoses <input type="checkbox"/> Tx/Recovery Plans
		<input type="checkbox"/> Medication Records <input type="checkbox"/> Demographic Information
Drug/Alcohol Treatment Information:		<input type="checkbox"/> Presence and Progress in Treatment
<input type="checkbox"/> Assessments	<input type="checkbox"/> Psychiatric Summary	<input type="checkbox"/> Diagnoses <input type="checkbox"/> Tx/Recovery Plans
		<input type="checkbox"/> Medication Records <input type="checkbox"/> Demographic Information
<input type="checkbox"/> Legal Information	<input type="checkbox"/> Other: _____	
Reason:	<input type="checkbox"/> Compliance with program, specify _____	
<input type="checkbox"/> Provide continuity of care	<input type="checkbox"/> Personal Use	<input type="checkbox"/> Insurance/Managed Care <input type="checkbox"/> Legal Purposes <input type="checkbox"/> Social Security/disability
	<input type="checkbox"/> Emergency, specify: _____	
Dates of Service From: _____ To: _____		

I understand that my personal health information (PHI) is protected under federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 that re-disclosure is prohibited, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by the HIPAA Privacy Law.

1. Review and understand the Notice of Privacy Practices.
2. This authorization is subject to revocation at any time, except to the extent that action has been taken in reliance on the authorization.
3. Inspect and receive a copy of the material to be released.
4. Request restrictions on how my health information is used and disclosed.
5. Receive a copy of this authorization and the Notice of Privacy Practices.

This form has been fully explained and I certify that I understand its contents and that RHCW may not condition treatment on obtaining this consent/authorization. This authorization expires one year from signature date unless revoked by client prior to that date.

Participant's Signature or Oral Consent when physically unable to sign

_____ Date

Signature of Authorized Person in lieu of Participant

Power of Attorney Guardianship Order

_____ Date

This authorization is valid for one year from date of signature.