Renewed Hope Counseling and Wellness
1550 N Crestmont Dr. Suite A, Meridian, ID 83642
P: (208) 288-4200
F: (208) 288-4279
operations@rhcwmentalhealth.com

Release of Information – Non-Emergency Contact

Patient Name: _____ Date of Birth: ___/___/___

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

Name: _____ Phone: _____

Relationship: _____

INFORMATION THAT MAY BE RELEASED
(please check all that apply)

Mental Health/physical Information: ☐ Presence and Progress in Treatment
☐ Assessments ☐ Diagnoses ☐ Tx/Recovery Plans
☐ Psychiatric Summary ☐ Medication Records ☐ Demographic Information

Drug/Alcohol Treatment Information: ☐ Presence and Progress in Treatment
☐ Assessments ☐ Diagnoses ☐ Tx/Recovery Plans
☐ Psychiatric Summary ☐ Medication Records ☐ Demographic Information

☐ **Legal Information** ☐ **Other:** _____

Reason: ☐ Compliance with program, specify _____
☐ Provide continuity of care ☐ Insurance/Managed Care
☐ Personal Use ☐ Legal Purposes ☐ Social Security/disability

☐ 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 Date
☐ Power of Attorney ☐ Guardianship Order

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