ENTERHEALTH
ADDICTION & MENTAL HEALTH TREATMENT

CONSENT AND AUTHORIZATION TO RELEASE INFORMATION
MEDICAL RECORDS REQUEST

I, _____, (D.O.B.) _____, hereby request and authorize the use and disclosure of health information as described below. I authorize Enterhealth (please check and initial all appropriate items):

CHECK & INITIAL: ❑ ___ **To Release Information To** ❑ ___**To Obtain Information From** ❑ ___**To Exchange Information With**

_____ _____ _____
Name of Person or Organization Relation to Client (Referral, Attorney, Spouse, Etc.)

_____ _____ _____
Street Address City/State/Zip Code

_____
Phone # Fax # Email

I request that the information be released in the following method(s) CHECK & INITIAL:

❑ ___written/photocopy ❑ ___verbal | ❑ ___ mailed ❑ ___ faxed ❑ ___ emailed ❑ ___telephone/1:1 consultation

Dates of Hospitalization/Treatment: _____

Specific extent of information to be included CHECK & INITIAL:

❑ ___ Nursing Assessment
❑ ___ Psychiatric Evaluation
❑ ___ Physician Orders
❑ ___ Psychosocial History
❑ ___ Psychological Evaluation Reports
❑ ___ History & Physical Exam
❑ ___ Notification of Discharge/Discharge Plan
❑ ___ Other (Specify): _____

❑ ___ Master Treatment Plan & Updates
❑ ___ Progress Notes (Medical, Nursing, Program)
❑ ___ Laboratory Work
❑ ___ Discharge Summary
❑ ___ HIV/AIDS or STD Information
❑ ___ Continuing Care Plan

This disclosure authorization is specifically intended to include any references to diagnosis, testing, and/or treatment for communicable diseases, including sexually transmitted diseases (e.g. – HIV/AIDS-related illness), mental health services, and drug and/or alcohol services governed by 42 CFR Part 2.

Reason for release of information CHECK & INITIAL:

❑ ___ Continuity of Care ❑ ___ Legal ❑ ___ Continued Medical Care
❑ ___ Other (Specify) _____

This is a voluntary authorization. Records will not be released unless this authorization form is signed and dated. I understand that I may revoke this consent at any time by giving written notice to the Medical Records Department of the Facility listed above. If revoked, the revocation will not apply to information previously disclosed under the consent. Information used or disclosed can no longer be protected by the privacy practices of this facility, and may be subject to re-disclosure. I further understand that the above consent will automatically expire one year from discharge. I agree to waive all claims against the facility for the release of the information defined above.

Attention recipient: This information has been disclosed to you from the records of a person whose confidentiality is protected by Federal Law. Federal Regulation (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 as otherwise permitted by such regulations. A general authorization for the release of the medical or other information is not sufficient for this purpose.

_____
Client Date

_____
Client Representative Date

_____
Enterhealth Staff / Witness Date

Client ID Label