Release of Confidential Information

Authorization to release information is voluntary; provision of services will not be denied due to refusal to sign authorization.

I, _____ SSN# _____ Date of birth:_____

authorize the staff of Interfaith Community Services to obtain information from and/or give information to:

Name/Organization: Interfaith Community Services

Address: 550 W. Washington Ave. STE B and/or 1617 Mission Ave.

Phone: 760-489-6380 and/or 760-529-9979

Disclosure of this information is for the following purpose:

Written and oral communication regarding medical/mental health treatment, housing and vocational purposes.

Please check type of information authorized:

Medical treatment	X	Psychiatric evaluation	X
Alcohol/Drug treatment	X	Biopsychosocial assessment	X
Educational records	X	Progress notes	X
Employment/Vocational assessment	X	Discharge summary	X
Other:			

I understand that my drug and/or alcohol treatment records are protected under Federal regulations governing Substance Abuse Patient Records (42 CFR, Part 2) and HIPAA (45CFR, Parts 160 & 162) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that the information in my records authorized for disclosure may include information about sexually transmitted diseases, HIV, and AIDS; it may also include information about mental health treatment and services. I understand the information disclosed by this authorization may be subject to redisclosure by the recipient and no longer be protected by the HIPAA regulations.

I also understand that I may revoke this consent at any time in writing except to the extent that action has been taken in reliance on it (e.g. probation, parole, etc.). This consent expires on _____ or if not specified, one year after signature or upon termination of the program. I have the right to receive a true copy of this completed form. I understand that a FAXED copy of this authorization may be used as an original.

Client Signature: _____   Date:_____

Staff Name: _____

Staff Signature: _____   Date:_____