Wiregrass Behavioral Group LLC

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Release of Information

CLIENT INFORMATION		In accordance with Federal Regulations 42 CFR part 2 and HIPAA, I hereby authorize Wiregrass Behavioral Group, LCC	
NAME		☐	To obtain records from
DOB		☐	To disclose and release records to
Last 4 SSN		Facility (Office/Clinic/Hospital)	
DATE			

Authorized entity / individual / agency:

NAME		ADDRESS	
PHONE			
FAX			

Information hereby authorized to be released:

	Psychiatric evaluation		Drug / Alcohol treatment
	Progress notes		Lab results
	Medication orders		Attendance
	Treatment recommendations & plans		Psychological testing
	Other (Specify) :		

For the time period of: Purpose for disclosure:

	All treatments		Comprehensive treatment
	Previous 6 months		Family involvement
	Previous 1 month		Aftercare / follow up / transition of care
	Specific time period of :		Continuity of care
	Other (Specify) :		Legal issues
			Other :

This Authorization will automatically expire 1 year after the date of authorization, or date specified here: _____

The confidentiality of the information being disclosed is protected by State and Federal law which prohibits you from making any further disclosure of it without the specific and informed release of the individual to whom it pertains, his/her authorized representative, or as otherwise permitted by law. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

Client Agreement

☐ I understand that I can refuse to sign this authorization. I understand Wiregrass Behavioral Group, LLC may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

☐ I understand that the information disclosed is protected by law and may not be re-disclosed without my written authorization or as otherwise authorized by law; however, I understand that Wiregrass Behavioral Group, LLC cannot control the recipient's use of the information.

☐ I have a right to revoke this authorization; I must do so in writing with name and date, and present my written revocation to Wiregrass Behavioral Group, LLC. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Signature of Client, Legal Guardian, or Authorized Representative	Date
Signature of Witness	**Date**