CHILD FOCUS
Strong families. Thriving communities.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Client Name _____ Date of Birth _____

I hereby authorize Child Focus to:

☐ Release Information to: ☐ Request Information from:

_____

_____

This information is to be released only to/from the individual or agency identified above.
The information is limited to the form(s) of information and the purpose(s) specified. It is not to be re-released to any other party.

Health Information to be disclosed to above named Individual or Agency:

- ☐ DAF/Assessment Reports
- ☐ Individual Service Plan
- ☐ Diagnosis
- ☐ Episode Notes
- ☐ Psychotherapy Notes
- ☐ Psychiatric Records
- ☐ Medication Summary
- ☐ Psychological Evaluation
- ☐ Confirmation Client Status
- ☐ Reproductive Health Records
- ☐ Treatment Summary/Recommendations
- ☐ Attendance/Service Records
- ☐ HIV/AIDS Records
- ☐ Drug/Alcohol Treatment Records
- ☐ Other: (Specify) _____

Health Information to be disclosed to Child Focus:

- ☐ DAF/Assessment Reports
- ☐ Individual Service Plan
- ☐ Diagnosis
- ☐ Episode Notes
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- ☐ Drug/Alcohol Treatment Records
- ☐ Other: (Specify) _____

Reason for Disclosure:

☐ Assessment ☐ Treatment Planning ☐ Case Management ☐ Collaboration/Coordination of Services ☐ Other: _____

I authorize information to be released from the record of ☐ the current/most recent treatment episode only; ☐ all treatment episodes.

This authorization will remain in effect until revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization any time by submitting written revocation in the manner specified by the disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. *If no date or event is specified below, this authorization will expire in one year.*

Expiration Date or Event: _____

I understand that I may not be denied treatment, payment, and enrollment in health plan, or eligibility for benefits for refusing to authorize disclosure unless such denial is permitted under state and federal law.

I understand that information disclosed by this authorization, except as prohibited by 42 CFR Part 2 or other applicable law, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance and Portability and Accountability Act Privacy Rule [45 CRF Part 164].

Client Signature* _____ Date _____

Staff Person Facilitating Request _____ Date _____ Agency/Staff Title _____

COPY TO CLIENT