



RELEASE OF INFORMATION

AUTHORIZATION TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

PRIVACY STATEMENT: Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose a social security number will not affect the disclosure of other information. Community Options, Inc. will not condition treatment on your agreement to authorize disclosure of your health information.

Customer Name: _____	Date of Birth: _____
Address: _____	
City/State/Zip: _____	Case Number: _____
I request and authorize Community Options, Inc. to release/receive case file information of the customer named above to:	
Name: _____	
Address: _____	
City: _____	State: _____ Zip Code: _____
<p>This request and authorization applies to:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Employment <input type="checkbox"/> Medical/Psychological Limitations <input type="checkbox"/> Education <input type="checkbox"/> Program Participation <input type="checkbox"/> Specific information to be released: _____ 	
<p>CLIENT CONSENT</p> <p>This authorization is voluntary and remains in effect until _____ (date) or _____ (event), unless specifically revoked by written notice to the agency or customer. Any information disclosed prior to written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this authorization is as effective as the original. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium, including oral, written, or electronic transmission.</p>	
Customer Signature: _____	Date Signed: _____
Guardian Signature: _____	Date Signed: _____
Witness Signature: _____	Date Signed: _____
<input type="checkbox"/> CHECK IF APPLICABLE – NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING ADDICTION RECORDS 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 authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.	

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED UNLESS NOTED DIFFERENTLY ABOVE.