The Affiliated Santé Group
Authorization for the Release/Exchange of Protected Health Information

Name of agency/person that information can be released to or exchanged with. ("Receiving Party")	Name of agency/person that information can be released from or exchanged with. ("Releasing/Exchanging Party")

I,_____, hereby authorize that the above-named Releasing/Exchanging Party shall release/exchange the following health information to the above-named Receiving Party:

☐ Results and recommendations of assessment	☐ Treatment Plan	☐ Discharge/Transition Pan
☐ Lab results	☐ Psychiatric Evaluation	☐ Medication information
☐ Participation and attendance	☐ Medical Information	☐ Information obtained from other agencies
☐ Entire Medical Record	☐ Other	

For the specific purpose of:

☐ Aiding in and coordinating services	☐ Legal purposes	☐ Insurance/Managed Care purposes
☐ Other (specify)		

This Authorization is valid until one year after the signature date, for the period of time needed to fulfill its purpose, or until the date expressed by the client (please indicate date if less than one year) _____.
The exception to this time period is in the case of disclosures for financial transactions, or as otherwise authorized by law, where the Authorization is valid indefinitely. I also understand that I have the right to revoke this Authorization at any time and that in order to do so I must sign the *Revocation Section* on this form. I further understand that any actions taken pursuant to this Authorization prior to the revocation date and time is legal and binding. I understand information may be released verbally, in writing, by mail, via secured electronic means or secured facsimile.

I understand that my information should not be re-disclosed by the requester of the information without my further written authorization and that this information may be protected by the Federal Substance Abuse Confidentiality Regulations. In any event the recipient should not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to chronic illnesses, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information unless I specifically exclude such information from disclosure.

I also understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), that service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed Authorization.

_____ _____ _____
Client Signature or legally appointed representative | Client Date of Birth | Date

_____ _____
Witness Signature | Date

Revocation Section

I do hereby request that this Authorization to disclose health information of _____ on _____
(client name) (Date of original signature)
be revoked, effective _____ at _____. I understand that any action taken on this Authorization prior to the revocation
(today's date) (time)
date and time is legal and binding.

_____ _____ _____
Client Signature | Date | Time

_____ _____ _____
Witness Signature | Date | Time

Verbal Revocation Section

I do hereby attest to the verbal request for revocation of this Authorization by _____ on _____
(Name of Client) (Date)
at _____. The client has been informed that any action taken on this Authorization prior to the revocation date is legal and
(time)
binding.

_____ _____ _____ _____
Staff Signature | Date & Time | Witness Signature | Date & Time