Family Visions
Authorization to Use and Disclose Protected Health Information

NOTICE – PLEASE READ: I understand that each authorization signed below will remain in effect for **180** days after I sign and date the form. Each authorization may be withdrawn at any time in writing except to the extent that action has already been taken. Upon receipt of written revocation, further release of information shall cease immediately, except as allowed by law. Recipients of this information are forbidden to re-disclose this information without my specific authorization.

I understand that if I have authorized Family Visions to disclose my information to person who are not required by Federal or State law to keep the information confidential, these persons receiving my records may disclose my protected health information to other without my consent or authorization. Family Visions will not be responsible for the misuse or re-release of information by another individual, agency, or entity.

Notice To Recipient Of Information: This information has been disclosed to you from records protected by Federal Confidentiality Rules. The Federal Rules **prohibit the recipient of the protected health information from making 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 Name:_____ Date of Birth**:**_____**/**_____**/**_____

I hereby authorize the Family Visions to:
☐ **disclose information** ☐ **request information** ☐ **exchange information**

With Name of Person or Entity: _____

Address:_____

Telephone/Fax:_____

INFORMATION TO BE USED/DISCLOSED

Initial the following items needed:

	Diagnostic Assessment/ Intake		Psychological Evaluation Reports		Treatment Plan/ISP
	Progress Notes		Psychiatric Evaluation		Other Social History
	Physician's Orders		Court Reports/Records		Medication Records
	School Records/ Consultation		Laboratory Reports		Employment Records/Reports
	HIV and AIDS Status		**Drug and Alcohol Addiction Records**		

Other (CLEARLY SPECIFY)_____

Purpose for Disclosure: ☐ Assist in Treatment Planning ☐ Continuity of Care

☐ Other (Specify)_____

_____

_____

I understand that I may withdraw this consent at anytime in the future as explained above and that this consent will expire in **180** days from the dates signed below, unless otherwise specified.

This consent will expire at (Event) _____ **OR**

when (Condition) _____ **OR** on ____/_____/_____whichever occurs

first, not to exceed 180 days.

Signature: _____ Relationship: _____ Date:_____

Witness: _____ Date: _____

NOTICE OF REVOCATION

I hereby, revoke authorization for further use and disclosure of my protected healthcare information effective immediately.

Client/Guardian Signature: _____ Date Revoked: _____