



**AUTHORIZATION TO
RELEASE/OBTAIN INFORMATION**

I, _____, authorize Castlewood Treatment Center to release/obtain information to/from:

Name: _____

Address: _____

Phone: _____

In regard to services provided to me during treatment. This disclosure will be made for the following purpose:

Specific information to be provided is to consist of the following:

- Narrative account of case history, course of treatment, prognosis, social history and discharge recommendations.
- Copy of patient's records including case history, course of treatment, prognosis and recommendations for ongoing treatment.
- Other Information (specify): _____

1. **READ CAREFULLY:** I understand that my medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of my medical/health information. The protected health information (PHI) in my medical record includes mental/behavioral health information. In addition, it may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable diseases, and/or alcohol/drug abuse.

2. Alcohol and drug abuse information records are specifically protected by federal regulations (42 CFR 2) and by signing this authorization without restrictions I am allowing the release of any alcohol and/or drug information records (if any) to the agency or person specified above. Please sign if you are authorizing the release of alcohol and drug abuse information:

3. This authorization includes both information presently compiled and information to be compiled during the course of treatment at the above-named facility or agency paying for services, during the specified time frame.

4. This authorization becomes effective on _____. This authorization automatically expires on the following date, event or special condition: _____.

5. If I fail to specify an expiration date, this authorization will expire in one year.

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so **IN WRITING** and present my written revocation to the health information management department (medical records) or client information center at this facility. I further understand that actions already taken based on this authorization, prior to revocation, will **NOT** be affected.

7. I understand that I have the right to receive a copy of this authorization. A photographic copy of this authorization is as valid as the original.

8. I understand that authorizing the disclosure of this medical/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my medical/health information I can contact the health information management director (medical records director) or client information center, or designee, or the Privacy Officer for this covered entity.

THE FOLLOWING APPLIES TO ALCOHOL AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS: Prohibition of Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for disclosure of medical information is NOT sufficient for this purpose.

My signature below acknowledges that I have read, understand, and authorize the release of my PHI.

Signature of Consumer	Date
Witness	Date
Signature of Parent/Legal Guardian/Representative	Date

(Please include a Description of Authority to Act on Consumer's Behalf and attach a copy of the Document Granting Authority, where applicable)

NOTICE OF REVOCATION

DATE	
I, _____, (Consumer) hereby revoke my authorization of this disclosure of information to the agency/person listed above. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on the authorization, prior to revocation, will not be affected.	
Signature of Consumer	Date
Witness	Date
Signature of Parent/Legal Guardian/Representative	Date
If you choose to revoke your authorization, please provide a copy of the completed revocation to the health information management director (medical records director), or the client information center, or to the Privacy Officer of this facility.	

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