**AUTHORIZATION TO RELEASE AND EXCHANGE INFORMATION**

**I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, AUTHORIZE CLINIC LOGISTICS AND SECURITY, DBA FULL CIRCLE RECOVERY SERVICES *TO RELEASE TO, OBTAIN FROM, OR EXCHANGE* WITH THE ORGANIZATION INDICATED BELOW INFORMATION CONCERNING TREATMENT OF THE CLIENT NAMED BELOW. THIS AUTHORIZATION INCLUDES *ELECTRONIC, ORAL, AND/OR WRITTEN COMMUNICATION*.**

|  |  |
| --- | --- |
| **CLIENT INFORMATION** | **PERSON/AGENCY RELEASING TO** |
| **NAME:** | **PERSON/AGENCY NAME:** |
| **SS#:** | **ADDRESS:** |
| **DOB:** | **CITY/STATE/ZIP CODE:** |
| **ADDRESS:** | **PHONE/CELL:** |
| **CITY/STATE/ZIP CODE:** | **FAX/EMAIL:** |

**THE PURPOSE OF THE RELEASE IS TO OBTAIN/DISCLOSE:**

* **CONTINUITY OF CARE**
* **EMERGENCY CONTACT/GENERAL UPDATES**
* **COURT SERVICES/LEGAL PURPOSES/DISABILITY CLAIM**
* **OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TYPE OF INFORMATION TO BE OBTAINED/DISCLOSED:**

* **PRESENCE IN TREATMENT**
* **PROGRESS IN TREATMENT**
* **TREATMENT PLANS**
* **PSYCHOLOGICAL ASSESSMENT**
* **PSYCHIATRIC HISTORY AND ASSESSMENT**
* **RESULTS OF PHYSICAL EXAM**
* **MEDICAL HISTORY/CURRENT STATUS**
* **BIOPSYCHOSOCIAL ASSESSMENT**
* **LABORATORY TEST RESULTS**
* **EMPLOYMENT INFORMATION**
* **LEGAL STATUS**
* **FAMILY INFORMATION**
* **AFTERCARE RECOMMENDATIONS**
* **DISCHARGE PLANNING**
* **DISCHARGE SUMMARY**
* **OTHER\_\_\_\_\_\_\_\_\_\_\_**

**HIPAA**

**I understand that my records are protected under Federal regulations (42 CFR Part 2) and the Health Insurance Portability Accountability Act (HIPAA), 45 CFR, pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it, and that in any event, this consent expires automatically one year from the date signed, otherwise unless specified below. I understand that generally Clinic Security & Logistics, Inc. may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances support or collateral investigation is a key component and we may not be able to meet your needs without the key contacts involvement. I understand I am entitled to a copy of this document in its complete form. This authorization shall remain valid until:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(not to exceed one year)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CLIENT SIGNATURE DATE**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CLIENT LEGAL GUARDIAN, RELATIONSHIP TO CLIENT DATE**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CLINIC SECURITY & LOGISTICS STAFF SIGNATURE DATE**

**I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_REVOKE THIS RELEASE ON\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **CLIENT SIGNATURE DATE OF REVOCATION**