



**Request/Authorization to Release Confidential Records and Information**

1655 W Fairview Ste #115  
Boise, Idaho 83702

1) Releasing records to:

Person or facility: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

2) Identifying information about me/the patient

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Parent/guardian (if applicable): \_\_\_\_\_

Address and phone of parent/guardian: \_\_\_\_\_

3) I hereby authorize the source named above to send, as promptly as possible, the records listed below marked by an X in the boxes below. (The items not to be released have a line drawn through them.)

Treatment plans

Progress Notes

Workshop and small group summaries

Billing records

A letter containing dates of treatment(s) and a summary of progress.

In consideration of this consent, I hereby release the source of the records from any and all liability arising therefrom.

This request/authorization is valid during the pendency of any claim or demand made by or in behalf of me/the patient, and arising out of an accident, injury, or occurrence to me/the patient. I understand that I may void this request/ authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive. If I do not void this request/authorization, it will automatically expire in 90 days from the date I signed it.

I agree that a photocopy of this form is acceptable, but it must be individually signed by me, the releaser, and a witness if necessary.

I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these.

I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request.

I authorize the source named above to speak by telephone with the therapist identified below, about the reasons for my/the patient's referral, any relevant history or diagnoses, and other similar information that can assist with my/the patient's receiving treatment or being evaluated or referred elsewhere.

\_\_\_\_\_  
Signature of client                      Printed name                      Date

\_\_\_\_\_  
Signature of parent/guardian/representative      Printed name                      Relationship                      Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

\_\_\_\_\_  
Signature of witness                                      Printed name                      Date

I, a mental health professional, have discussed the issues above with the patient and/or his or her parent or guardian. My observations of behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

\_\_\_\_\_  
Signature of professional                                      Printed name                      Date

This request/authorization to release confidential information is being made in compliance with the terms of the Privacy Act of 1974 (Public Law 93-579) and the Freedom of Information Act of 1974 (Public Law 93-502); and pursuant to Federal Rule of Evidence 1158 (Inspection and Copying of Records upon Patient's Written Authorization). This form is to serve as both a general authorization, and a special authorization to release information under the Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255), the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974 (Public Law 93-282), the Veterans Omnibus Health Care Act of 1976 (Public Law 94-581), and the Veterans Benefit and Services Act of 1988 (Public Law 100-322). It is also in compliance with 42 C.F.R. Part 2 (Public Law 93-282), which prohibits further disclosure without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulations. It is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191.

- Copy for patient or parent/guardian       Copy for source of records       Copy for recipient of records