AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I _____ , on behalf of _____ , hereby
(name of client or authorized representative (i.e.: parent, guardian…) (if applicable write minor's name or write "my self"

authorize Marc D. Richter to: (place √) ____ Request & receive the following indicated pertinent & relevant information;
(name of provider)
_____ Disclose or release the following indicated pertinent & relevant information;

To/From: _____
(Name of program/agency or provider)

Please **INITIAL** *each line as applicable below:*

____ My Mental Health Record in its Entirety,
____ My Substance Abuse Record in its Entirety,

OR ***Only the following information*:**

___ Substance use/abuse history
___ Psychological Evaluations
___ History of Psychiatric Treatment
___ Treatment Plan(s) or Summary
___ Progress Notes
___ Drug & Alcohol Toxicology Screens
___ Other: _____
___ Diagnostic summary and diagnoses
___ History of Medical Treatment
___ Intake summary/assessment
___ Presence/Progress in Treatment
___ Expected length of treatment
___ Attendance records only
___ Social/Family history
___ Legal History
___ Course and results of treatment
___ Demographic Information
___ Verbal exchange of information
___ Evaluations (substance abuse, mental health)

_____ I understand that the information released may include information pertaining to substance abuse and/ or dependence.
_____ I understand that the information released may include information pertaining to HIV infection, AIDS or tests for HIV.

The purpose of the disclosure authorized by this consent is:_____

I understand that (if applicable) my alcohol / drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 C.F.R. Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. parts 160 & 164 and cannot be disclosed or further re-disclosed by the designated recipient of this information unless expressly permitted by the written consent of the person to whom it pertains, or unless otherwise provided for in the regulations. I also understand that my behavioral health records are confidential and protected from unauthorized disclosure. I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal/state law.
I understand that I may revoke this authorization/consent at any time by notifying the provider in writing, except to the extent that action has been taken in reliance on it. Thus, I understand that my revocation will not affect any actions taken by my provider before receiving my written revocation.

This consent/authorization shall be valid for one year from the date below and shall expire two (2) years from the Date of Signature below **or** upon the *date*, *event*, or *condition* noted here, **or** unless sooner revoked in writing: _____.
I have not been coerced to sign this authorization. I understand that I might be denied services if I refuse to consent to a disclosure for the purposes of treatment, payment, or health care operations, if permitted by state law. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits nor will I be denied services if I refuse to consent to a disclosure for other purposes. I understand that prepayment for copies of my records as well as payment for services rendered may be required for copies of my record when released to anyone other than a medical provider, facility or institution.

I understand that by signing this form I am confirming my authorization for use and/or disclosure of the protected health information described above with the people and/or organizations named above. I have read this release and understand its contents. I have also been provided a copy of this form.

_____	_____	_____	_____
Signature of Client	**Print Name of Client**	**DOB**	**Date of Signature**

Print Name of Personal Representative or person signing for client: _____
Relationship to client (parent, guardian, etc.)/Authority to sign: _____
Signature of Personal Representative: _____ Date: _____