Family Service Request for Records

Client Name:

Date of Birth:

D&A, MH, or HIV-related information cannot be used/disclosed in reliance on this form unless specified explicitly as such. D&A and HIV-related disclosures must be accompanied by disclosure statements required verbatim by federal and state laws .I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). 45 CFR, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

I authorize Family Service to request my protected health information, as described below, to the following person or entity (name/agency/relationship/phone number):

_____

This authorization allows Family Service to request records for the following purpose(s):

- ☐ Substance Use Treatment Information
- ☐ Continuity and Coordination of Care
- ☐ Recommendations
- ☐ Other

This authorization covers following information about me:

- ☐ Presence in Treatment
- ☐ Screening and Lab Results
- ☐ Medication Records
- ☐ Diagnoses
- ☐ Progress
- ☐ Evaluations and Assessments
- ☐ Treatment and Discharge Recommendations
- ☐ Other

This authorization permits Family Service to request the selected information from the following person or entity. I understand that I have the right to revoke this authorization at any time either by verbal or written notification to Family Service, which becomes effective immediately. I understand that Family Service may request that I sign a notification form which will be placed in my record. I may not revoke this authorization to the extent that Family Service has already relied upon it or if it was signed as a condition of obtaining insurance coverage. Family Service is prohibited from re-disclosing records released by external parties, unless otherwise provided for under CFR 42 and 45 as noted above. I understand that Family Service may not require that I sign this authorization in order to obtain treatment. I have read this authorization or had it explained to me, and I understand its contents.

In absence of revocation, this authorization is signed becomes effective on:_____ and expires on: _____

I am entitled to a copy of this consent form. **Accepted_____** **Refused_____**

Signature of Client Date Signature of Witness Date