FRIENDS RESEARCH INSTITUTE
Advancing research to promote health and well-being

AUTHORIZATION TO RELEASE INFORMATION (TREATMENT PROVIDER RECIPIENT)

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

REMEMBER: Information disclosed pursuant to client consent must be accompanied by the notice prohibiting redisclosure.

Client Name:

I, the above-named client of EPOCH COUNSELING CENTER, authorize Friends Research Institute, Inc. as follows:

Information to be Disclosed (describe how much and what kind of information may be disclosed, including an explicit description of what substance use disorder information is to be shared):

___ Assessment	___ Diagnosis	___ Urinalysis results	___ Recommendations
___ Discharge Summary	___ Prescriptions	___ Biopsychosocial History	___ Mental health records
___ HIV status	___ Legal History	___ Substance use history and treatment	
___ Attendance	___ Entire record		

Individual/Entity to Receive Information

Name of Intended Receiver: _____

Relationship: _____

Address: _____

Fax No.: _____

Phone No.: _____

Purpose of Disclosure

___ For medical care	___ To satisfy Social Services requirement	___ To satisfy MVA requirement
___ For legal purposes	___ To determine eligibility for Social Security	
___ For payment	___ Other, specify:_____	

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Expiration

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this authorization will automatically expire as follows (SHOULD BE THE SHORTEST TIME NEEDED TO ACCOMPLISH THE PURPOSE, NOT TO EXCEED ONE YEAR FROM THE DATE THAT THIS FORM IS SIGNED):

Date to expire (no longer than one year): _____

Condition for expiration: _____

Event for expiration: _____

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes

I have been provided with a copy of this form. ____ (Initials)

I decline to accept a copy of this form. ____ (Initials)

Signatures

_____ _____

Client Signature Date Signed

If you are NOT the client but are signing on behalf of the client, please complete below and attach proof of your authority to act on behalf of the client.

I, _____, am the (check which applies)
(print your name)

- ☐ **Court Appointed Guardian**
- ☐ **Court Appointed Personal Representative of Deceased**
- ☐ **Parent with Parental Rights** *(requires Release of Information form signed by client)*
- ☐ **Attorney** *(requires Release of Information form signed by client)*

Representative's Signature: _____ **Date**: ____/____/____ (Required)