AUTHORIZATION FOR EXCHANGE OF INFORMATION

(with your Medical provider)

Client:		Date:
Parent/Guardian:		Phone:
Mailing Address:		
City:	State:	Zip:
Clients DOB:		

Completion of this document authorizes the use or disclosure of individual identifiable health information, as set forth below, consistent with State and Federal law concerning the privacy of such information.

I, _____ hereby authorize the use or disclosure (verbal and written) of my protected health information, or my child's protected health information (if under 18) between *Positive Connections Plus* and:

Primary Care Physician/Provider:		
Address:		
City:	State:	Zip:
Phone:	Fax:	

Expiration Date of Authorization: ____/____/_____
(Indicate date, or an event relating to you or to the purpose of the authorization).

The following information is requested (**Client needs to initial next to each that applies**):

_____Psychosocial History/Intake
_____Psychiatric Evaluation
_____Psychological/Educational Testing
_____Diagnoses
_____Assessments
_____Medical Records/H&P
_____Dates of Treatment
_____Treatment Plan(s)
_____Aftercare Plan
_____Financial Obligations
_____Verbal/Written Exchange
_____ Other: _____

The purpose of this exchange is to facilitate treatment, summarize treatment and/or coordinate aftercare planning. I understand that I may revoke this consent at any time, except information already released. If not revoked in writing, this consent will expire in one year from the date below at my request.

Signature of Client/Parent/Guardian Date

Received by Positive Connections Plus Staff Date

ONLY SIGN BELOW IF REFUSING OR REVOKING CONSENT

I *refuse* or *revoke* my consent for your use and disclosure of my protected health information for treatment.

Signature of Client/Parent/Guardian Date

Disclosure: This information has been disclosed to you from the records whose confidentiality is protected by law. Federal regulations, (42CFR part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be subject to fines.