East House
moving lives forward

Authorization to Release/Obtain Information

CLIENT'S LAST NAME	FIRST	M.I.
DATE OF BIRTH		
PROGRAM/LOCATION		

The following information (check all that apply):

- ☐ Intake/Screening Assessment
- ☐ Current Treatment/Service Plan
- ☐ Attendance & Progress Reports
- ☐ Discharge Summary
- ☐ Legal Information
- ☐ Financial / Benefit Information
- ☐ Medical/Dental/Lab Reports
- ☐ Psychiatric/Psychological Evaluation
- ☐ Psychosocial Summary
- ☐ Vocational Rehabilitation Report
- ☐ School/Training Performance Report
- ☐ Employment Performance Report
- ☐ Other _____

For the purpose(s) (check all that apply):

- ☐ Evaluation for Services
- ☐ Coordination of Professional Services
- ☐ Obtain/Retain Insurance/Financial Benefits
- ☐ Education/Training/Employment Assistance
- ☐ Disability Determination
- ☐ Legal Assistance
- ☐ Education/Support/Coordination of Services with Family/Concerned Other
- ☐ Housing Assistance
- ☐ Other _____

This consent is valid for the following period (indicate one of the following):

☐ I hereby authorize the **one-time release** of the above information to the person/organization/ facility/program identified above. I understand that the information to be released is confidential and protected from disclosure. I also understand that I have the right to cancel my permission to release information at any time.

☐ I hereby authorize the **periodic release** of the above information to the person/organization/ facility/program identified above **as often as necessary to plan for/provide care and treatment. I understand that this consent is in effect until I cancel my permission to release information or until 3 months after discharge from an East House program.** I understand that the information to be released is confidential and protected from disclosure. I also understand that I have the right to cancel my permission to release information at any time.

I understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations (addictions clients), Mental Hygiene Law Section 33.13 (mental health clients), and the Health Insurance Portability and Accountability ACT of 1998 (HIPAA) 45C.F.R. Parts 160 and 164, and that re-disclosure of this information without my additional written authorization is prohibited. Any information I authorize other agencies to release to this facility will be held strictly confidential and will not be released without my permission.

Client signature: _____ Date: _____

Witness signature: _____ Date: _____

REVOKED: (Only to be used when a client revokes consent)

Client Signature_____ Date: _____

Original (Chart) Copy (client)