Authorization To Release Protected Health Information

Client Name: _____ DOB: _____ SS#: _____

I hereby authorize **SAGE WELLNESS CENTER, LLC** to:

☐ Release to ☐ Obtain from

The below information for the above client:

_____ Entire outpatient record – Date range _____
_____ Letter of attendance
_____ Letter of diagnosis
_____ Psychiatric evaluation only
_____ Other: (please specify): _____

____ Coordination of care letter
____ Medication history only
____ Treatment plan only
____ Progress notes only

Name, Address, Phone #, Fax # health provider or person where records should be sent to or obtained from:

_____

_____

The purpose or need for such disclosure is to help provide therapeutic services. The information may be given as needed. This authorization form implements the requirements for client authorization to use and disclose health information protected by the federal health privacy law, 45 C.F.R. parts 160, 164; the federal drug and alcohol confidentiality law, 42 C.F.R. part 2; and NJ confidentiality law governing mental health and substance abuse services.

I understand that these medical records contain information pertaining to psychiatric counseling or testing; alcohol/drug abuse counseling or testing; and/or HIV diagnosis or testing. I do expressly and voluntary authorize the disclosure of this medical record information to the person(S) and/or entity (ies) as stated above.

Once I have signed authorization to release this information, I understand that the federal privacy law (45 C.F.R. part 164) may not apply to who receives this information and, therefore, the information could be given to others. However, other laws may prohibit this. When i disclose mental health information protected by the state (NJ Administrative Code Title 10) or substance abuse treatment information protected by federal law (42 C.F.R/ Part 2), I inform those I am sending this to that releasing it again is prohibited except in the circumstances that the law allows. The Notice of Privacy Practices describes those circumstances for disclosing information.

This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon, and will otherwise expire on (indicate date/event/or condition) _____ BUT NO LONGER THAN FOUR MONTHS FROM DATE OF CONSENT UNLESS OTHERWISE NOTED. I understand that I may refuse to sign this consent. I understand that **SAGE WELLNESS CENTER, LLC** will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I sign this authorization, unless: (A) The treatment being provided is research-related and the protected health information is to be used for research; or (B) The services being provided is solely for the purpose of providing the protected health information to a third party.

Date: _____ Sign: _____
Client signature

Date:_____ Sign: _____
Witness