

Standard Client Authorization to Release and Exchange Basic Information

CLIENT NAME: (first, middle, last _____)

DATE OF BIRTH: _____

SOCIAL SECURITY NO: _____

In accordance with Federal Regulation Code 42, Part 2, 1 hereby authorize:

| | | |
|---------------------------------------|---------------------------|---------------------------------|
| Name of homeless service organization | To release to/share with: | _____ |
| Address | (please circle) | Name of individual, institution |
| Contact Information | | _____ |
| | | Address |
| | | _____ |
| | | City, State, Zip |
| | | _____ |
| | | Phone, Fax |

The following information: (including patient records related to any attempted suicide, emotional illness, psychological services records, if any, social services records, if any; including communications made by me to a social worker, counselor, psychologist, physician, or other health care provider; and information regulated by Federal Public Law 93-282, confidentiality of alcohol and drug abuse patients and records documenting the diagnosis and/or treatment of communicable diseases and /or serious disease and infections as defined by the US Department of Health and Human Services rules which include venereal disease, tuberculosis, AIDS, ARC, HIV status and other related diseases, if any)

| | |
|--|-----------------------------------|
| _____ Diagnosis/Test Results: | _____ Discharge/Treatment Summary |
| _____ Medical Records/ Hospital Records | _____ Police/Prison Records |
| _____ Psychological/Psychosocial Assessments | _____ Financial Information |
| _____ Substance Abuse Assessments/Evaluations/History | _____ Housing Requirements |
| _____ Psychiatric Evaluation/Consultation /Medications | _____ Transportation Requirements |
| _____ Diagnostic Impressions/Prognosis | _____ Nutritional Requirements |
| _____ Treatment Plan/Treatment Recommendations | _____ Chart/Progress Notes |
| _____ Other (please describe) _____ | |

for services covering the dates from: _____ to _____ for the specific purpose of _____ I release the above cited individuals or facilities of any legal liability that may arise from the release of the information requested. I understand that the agency cannot release information obtained from other sources. I understand that the individual/institution/agency receiving this information may not re-release it to any other individual, institution or agency. I also understand that this authorization for release of information will expire on _____ unless indicated below:
(not to exceed 180 days)

Condition, date or event of earlier expiration _____
I also understand that this release can be revoked, by me at any time and that the revocation must be signed and dated by me, and that the revoking of the release will not affect information released prior to the revoking of the release.

| | | |
|-----------------|------------|-------------------------------|
| _____ Signature | _____ Date | _____ Relationship (if minor) |
|-----------------|------------|-------------------------------|

| | | |
|----------------------------|-------------------------|------------|
| _____ Witness Name (PRINT) | _____ Witness Signature | _____ Date |
|----------------------------|-------------------------|------------|