

**Authorization of Release and Exchange of Information**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City, State and Zip: \_\_\_\_\_

I authorize Heart to Hand, Inc. to obtain and/or release information from:

Name of Provider or Facility: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, and Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Type of Records Authorized:

- Psychiatric/Psychological Evaluation and/or Treatment
- Drug/Alcohol Evaluation and/or Treatment
- HIV/AIDS information (labs, medications, progress notes)

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/programs identified as often as necessary to fulfill the purpose identified in the document.

My Authorization will expire:

- When I am no longer receiving services from Heart to Hand, Inc.
- One Year from this date
- Other \_\_\_\_\_

***I understand that:***

- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain services.***
- I may cancel this authorization at any time by submitting a writing request to Heart to Hand, Inc.***
- If the authorized information is protected by Federal Confidentiality Rules 41CFR, part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulation.***

Signature of Patient or Patient's Legal Rep: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name (if not patient): \_\_\_\_\_

I acknowledge that the patient or patient's legal representative has been provided a copy of this authorization.

Agency Rep. Signature (Witnessed & Explained by): \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_