LINK HOUSE INC.
PROVIDING THE TOOLS TO MAINTAIN LONG-TERM RECOVERY

CENTER FOR BEHAVIORAL HEALTH & ADDICTION TREATMENT SERVICES

Authorization to Obtain or Release Information and Records

Client Name: _____DOB _____ Clt.MIS# _____

I, _____authorize the Link House to ___Obtain and / or ___ release by fax, mail, or verbally information including medical and/or mental records to/from:

_____
(Name and telephone number of agency/school/physician)

_____
(Complete mailing address of agency/school/agency)

Dates of Service: _____ (if not otherwise directed, records for the last 12 consecutive months of treatment will be released.
Please indicate the **SPECIFIC** information to be disclosed: (please complete each category)

Y N Clinical Assessment Information
Y N Treatment Plans
Y N Medical Health Summaries
Y N School Information
Y N Psychological / Neuropsychological Testing Results
Y N Other (CRS, Day Treatment, ACT)
Y N Progress/Collateral Notes
Y N Discharge Summary
Y N Psychopharmacology
Y N Summaries and Medications
Y N Substance abuse screening results

The purpose of this release of information is:
____ Assistance in Treatment Planning ____Coordination of Treatment ____Evaluation
____ Other (Specify) _____

Protected Information
I understand that the records below cannot be disclosed without my specific written consent as indicated by my initials. The authorization to release pertaining to these protected categories is only valid for 90 days after treatment termination.
INITIAL ONLY THE CATEGORIES OR INFORMATION YOU WISH LINK HOUSE TO RELEASE/OBTAIN:

____Alcohol and/or Substance Abuse
____HIV/AIDS Results/Treatment
____Hepatitis B/C Testing/ Treatment
____ Sexually Transmitted Diseases
____ Sexually Assault / Counseling
____ Domestic Violence / Counseling

I understand that I have the right to inspect and copy the information to be disclosed, and that I may withdraw this Authorization at any time except to the extent that action has been taken in reliance upon it. I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, ***42 CFR Part 2,*** **and cannot be disclosed without my written consent unless otherwise provided in these regulations.**

_____ _____
Signature of Client Date

_____ _____
Signature of Witness Date