**RELEASE OF INFORMATION- HAMPDEN**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize **Thrivur Health** to:

□ Disclose to □ Obtain from

□ Electronic □ Oral □ Written

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The following information:**

□ Attendance/presence in treatment

□ Progress in treatment

□ Treatment plans

□ Assessments

□ Psychiatric history and assessment

□ Results of physical examination

□ Medical history/current status

□ Laboratory test results  
□ Employment information

□ Legal status

□ Family information

□ Aftercare recommendations

□ Discharge planning

□ Discharge summary

□ Substance use disorder information

□ Psychiatric conditions

□ HIV or AIDS related information

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for release of information:**

□ Care coordination □ Legal □ Collateral information

□ Emergency contact □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_ I understand that my alcohol and/or drug treatment records are protected by federal law and regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, by the Health Insurance Portability and Accountability Act (HIPAA) and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

\_\_\_\_\_\_\_ I also understand that recipients of this information may not redisclose this information without my written consent.

\_\_\_\_\_\_ I understand that I may revoke this authorization at any time upon written notice to Thrivur Health. I acknowledge that such revocation will not be effective if Thrivur Health has already acted in reliance upon this authorization.

This authorization is valid (if not previously revoked) this consent will terminate upon 2 years from the date of signature of this form, or the completion of treatment, or at the time of the final insurance billing, as the case may be, whichever is later.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Client’s Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s or Responsible Party’s Signature Date

If signed by Responsible Party, please state relationship to client and authority to consent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Revocation: I hereby revoke the above authorization effective immediately. I understand that the health information may already have been disclosed pursuant to and in reliance on my prior Authorization. I also understand that this revocation applies only to the information specifically described in the above-referenced document and does not affect any prior executed Consents to release information for treatment, payment or health care operations, or any prior executed Authorizations for other information.***

***Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***