Authorization for Release and Exchange of Information

I understand that in order to gain the most benefit from my progress, it may be helpful for information to be exchanged for the purpose of obtaining collateral information, allow for consultation and/or coordination of services between Holman Recovery Center and other involved professionals, or family members.

Client Name: ____________________________ Other Name: ________________________________
D.O.B.: __________________________________ SSN: ____
Address: ________________________________ City, State, Zip: ______________________________
____

To ***exchange*** information as identified and checked below: **I hereby authorize Holman Recovery Center and**

Name: _____________________________________ and ____
(Person we are exchanging information with) (Business Name/ organization the individual works for)
Address: _________________________________ City, State, Zip: ___________________________________
Phone: (___) ______________________________ ___________________________________
Cell Phone: (___) __________________________
Fax Number: (___) __________________________ Email: _______________________________________

❑ Assessments and Recommendations ❑ Case Management
❑ Substance Use Disorder Evaluation/ Treatment ❑ Progress/ Case Notes
❑ Biopsychosocial, Developmental/ Social History ❑ Legal Involvement and Records
❑ Treatment or Action Plan/ Summary/ Progress ❑ Consultations
❑ Psychological/ Psychiatric Evaluation and Records ❑ Demographics
❑ Medical Records (Including Medication/ Drug and Alcohol Tests) ❑ Emergency
❑ Discharge Summary/ Discharge Planning and Recommendations ❑ Other (Specify): _______________
❑ Academic Records/ Evaluations/ Staff Observations ❑ Other (Specify): __________________________

Revocation: I am aware that any cancellation or modification of this authorization must be in writing and received by *Holman Recovery Center*, to be effective. I have the right to revoke this authorization at any time and authorization will not affect any information already released. This authorization is valid during the pendency of any claim or demand made by or on behalf of me, and arising out of an accident, injury, or occurrence to me. Unless sooner revoked, this consent expires 1 year from date of last service.
Conditions: I understand that no services will be denied solely because I refuse to consent to this release of information, and that I am not in any way obligated to release these records. I do release them because I believe that they are necessary to assist in my success.
Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.
Redisclosure: Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. I will be given a copy of this authorization for my records at my request.
With this, I release and hold Holman Recovery Center, harmless from any liability for the release of any information provided in accordance with this directive.

Client Signature ____ **Date** _____________________________

Signature of Witness ____ **Date** ____________________________