



Consent for Release of Confidential Health and/or Mental Health Information

DOC Facility Name: _____

Address: _____

Telephone #: () _____ Fax #: () _____

Offender Name:		DOC #:	
DOB:		SS#:	

I hereby authorize: _____ () _____ ()
Name and title of organization/practitioner/person Phone # Fax #

Street Address City State ZIP

to release/use/disclose the following information: **(Check all that apply)**

- Discharge Summary(ies) Mental Health Evaluation(s)
 Consultations Progress Notes Physician Orders
 Lab Work Treatment Plans Risk Assessments
 History and Physical Substance Abuse Information* Entire Medical Record
 Other: _____

Per Federal Confidentiality Rules (42 CFR part 2) I am expressly permitting the specific release of substance abuse related information: YES NO _____ Offender's initials

To: _____ () _____ ()
Name and title of organization/practitioner Phone # Fax #

Street Address City State ZIP

Purpose of release/use/disclosure of information is: Diagnosis/Treatment Discharge Planning (other) _____

As the person signing this authorization, I acknowledge that I am giving permission to the above named individual or entity to disclose and use protected health care information. I have been informed that:

- DOC cannot make the provision of treatment to me conditional upon my signing of this authorization
- The original of this authorization shall be included in my Health Record and a notation concerning the individuals or entities to which disclosure was made shall be included with my original records
- I have the right to revoke this authorization at any time. I understand that the revocation is not effective until delivered in writing to the person in possession of my records
- There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and, therefore, no longer protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

Unless revoked, this authorization will expire: (specify date or event): _____

This information may be disclosed effective: Immediately _____ (specify date)

Signature (Offender) _____ Date

Signature (Witness) _____ Printed Name (Witness) _____ Date

cc: Health Record