

Insight Clinical Counseling and Wellness Authorization for Release of Information

Section I (Client Information)					
First Name:	MI:	Last Name:	DOB:	Social Security Number	
Address:			City:	State:	Zip:
I hereby authorize the disclosure of health information about the above individual as follows.					
Section II					
Disclosing Entity (Name of the Holder of records):			Telephone Number:		
Address:			City:	State:	Zip:
The information is to be provided to the following:					
<input type="checkbox"/> Named Individual: _____ <input type="checkbox"/> Named Third Party Payer (an entity that provides medical services, health plans, or insurance by contract or agreement): _____ <input type="checkbox"/> Named Treatment Provider Entity (healthcare professional): _____ <input type="checkbox"/> Named Non-Treatment Provider (such as an intermediary or research entity)					
<i>If non-treatment provider is selected complete a, b, and/or c below</i>					
a. Named Individual Participants: _____ b. Named Treatment Provider Entity Participant(s): _____ c. Description of Group or Class of Treatment Provider Entity Participant(s): _____					
Contact Information (e.g. telephone number, email address, fax number, street address, etc.)					
Section III					
Reason for Disclosure					
Health information to be disclosed					
Specify time period, if desired:					
Release only information from the period _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)					
Section IV					
This authorization will remain in effect until revoked or shall expire on date or event specified below, I understand that I may revoke or cancel this authorization at any time by submitting writing revocation in the manner specified by the disclosing entity, except to the extent that action has been taken in reliance of this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event state below. If no date or events has been specified below, this authorization will expire in one year.					
Expiration Date or Event: _____ (mm/dd/yyyy)					
<p>This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose (see 42 CFR 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 CFR 2.12(c)(5) and 42 CFR 2.65.</p> <p>42 CFR part 2 prohibits unauthorized disclosure of these records.</p>					
Signature of Individual				Date (mm/dd/yyyy)	
Signature of Personal Representative (if applicable) (identify relationship to individual below)				Date (mm/dd/yyyy)	
Relationship of Personal Representative to Individual (Personal representative shall submit proof of authority to the disclosing entity)					
<input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Healthcare Power of Attorney <input type="checkbox"/> Executor/Administrator <input type="checkbox"/> Other <input type="checkbox"/> N/A					