Leominster Outpatient Release of Information

Inspire Counseling and Support Center/The Transition House, Inc.

Authorization for Release of Confidential Information

Please select one or both below: *

- ☐ Obtain
- ☐ Release

Entity Name: *

Entity Address: *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Entity Phone Number: *

Please enter a valid phone number.

Client Name *

First Name Last Name

Client Date of Birth *

Month Day Year

Information to be Obtained and/or Released *

- ☐ Treatment Recommendations
- ☐ Compliance or non-compliance with program activity
- ☐ Record of attendance & participation in program activity
- ☐ Frequency and results of urine drug screens
- ☐ Inspire/TTHI representative summary notes
- ☐ Medical, mental health, psychiatric, alcohol/drug abuse records
- ☐ ALL OF THE ABOVE
- ☐ Other (please indicate below)

Other:

The purpose of obtaining and/or releasing this information: *

- ☐ Facilitate emergency care
- ☐ Determine need and eligibility for additional or alternative services
- ☐ Confirm status in program
- ☐ Assessment and treatment facilitation
- ☐ ALL OF THE ABOVE
- ☐ Other (please indicate below)

Other:

Authorization: I certify that this request has been made freely, voluntarily, and without coercion and that the information given is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written recovation is effective upon receipt of the Release of Information Unit at the facility housing the records. Re-disclosure of my medical records by those receiving the above-authorized information may be accomplished without my further written authorization and may no longer be protected. Without my expressed revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on (date supplied by client); (3) under the following conditions:
I understand that tmy records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. For court ordered clients, this information may be re-disclosed for open court per conversation between the treatment provider, judge, and attorneys. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

Release of Information Expiration: *

- ○ 90 days post-dischage
- ○ On the below date:

Date of expiration:

Month Day Year

Client Social Security Number:

Date *

Month Day Year