Authorization to Release, Obtain, and / or Exchange Information

CLIENT:

_____ (Name of client) (D.O.B.)

_____ (Street Address)

_____ (City, State, Zip Code)

I HEARBY AUTHORIZE:

_____ (Name of Provider)

_____ (Street Address)

_____ (City, State, Zip Code)

To ☐ **obtain from** ☐ **release to** and/or ☐ **exchange** health information and school records with TerraVista Retreat 18165 Midland Blvd, Nampa, ID 83687 - 208.515.6013

Description of Information to be Disclosed: (Patient/Client should initial each item to be disclosed)

_____ Assessment

_____ Diagnosis

_____ Psychosocial Evaluation

_____ Psychological Evaluation

_____ Psychiatric Evaluation

_____ Treatment Plan or Summary

_____ Current Treatment Update

_____ Medication Management Information

_____ Presence/Participation in Treatment

_____ Nursing/Medical Information

_____ Educational Information

_____ Discharge/Transfer Summary

_____ Continuing Care Plan

_____ Progress in Treatment

_____ Demographic Information

_____ Psychotherapy Notes*

(*Cannot be combined with any other disclosure)
_____Other_____

_____Other_____

Purpose of Release: The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Notices:

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to:

TerraVista Retreat 18165 Midland Blvd, Nampa, ID 83687

I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration: Unless sooner revoked, this authorization expires on the following date: _____or as otherwise indicated:

Conditions: I further understand that TerraVista Retreat Center will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

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 tto, verbally, in paper format, or electronically.

Redisclosure: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this disclosure for my records.

(X) _____ Date_____

Client Signature or Person Authorized to Consent Date

_____Date_____

Signers Name (if signed by representative rather than client)

Signer's Authority_____ (If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.)

☐ Check here if patient/client refuses to sign authorization Signature of staff witness

Signature of staff witness _____Date _____