familylinks
Strong. For life.

Authorization for the Release of Information

Client Information			
Client Name		Client Date of Birth	
Client Phone:		Medical Records Number (MRN)	

I Authorize Familylinks to:		
☐ Release	☐ Obtain	☐ Release and Obtain

Information To/From the Following Organization/Individual:

Name of Facility/Individual			
Address			
Phone Number		Fax Number	

Purpose of Record Release:

☐ Coordination of Care	☐ Payment for Services	☐ Support Services
☐ Emergency Contact	☐ Legal Requirement	☐
☐ Other (please provide detailed description of purpose):		

Release of Special Protected Information	
I Authorize Familylinks to Release the Following Information:	
☐ Mental/Behavioral Health Records	☐ Drug and Alcohol Records
In accordance with Pennsylvania's Act 147 of 2004, a parent or legal guardian's releasing records of minors ages 14-17 is limited to direct release from a mental health treatment provider to another treatment provider or to a primary care provider.	Please indicate which of the following to release: ☐ Whether the client is or is not in treatment ☐ The prognosis of the client ☐ The nature of the program ☐ A brief description of the progress of the client ☐ A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.

Records to Be Released:		
Please Select Department:		
☐ Inpatient	☐ Outpatient	☐ Service Coordination Unit
☐ Youth and Family Services	☐ Medical Services	☐ Vintage
Please Indicate Dates of Service	**From:**	**To:**
Please Select Each Item to Be Released:		
☐ Assessment	☐ Physician Orders	☐ Discharge/Transfer Summary
☐ Progress/Psychotherapy Notes	☐ Progress in Treatment	☐ Continuing Care Plan
☐ Psychosocial Evaluation	☐ Psychiatric/Psychological Evaluation	☐ Legal/Court Documentation
☐ Medication Records	☐ Nursing/Medical Records	D&A treatment status & progress
☐ Current Treatment Update	☐ Participation in Treatment	D&A diagnosis

☐ Educational Information	☐ Treatment Plan	Service notes/Journals
☐ Other:		

HIV – parts of the records indicated above may contain HIV-related information and will be released through this authorization unless otherwise indicated. ☐ Do not release

Important Information
Expiration & Revocation
Unless sooner revoked, this authorization expires one year from the date of signature. Authorization for releases will not exceed one year from the date of signature. I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to or the entity/person I authorized above to release the information. A verbal request to revoke this authorization is sufficient for information protected under the drug and alcohol regulations. Decision to revoke the Authorization does not apply to any release of my records that may have taken place prior to the date of my revocation of the Authorization. If applicable, please indicate other expiration date here: _____
• My decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care and I understand that I may be responsible for payment of the claim. • Familylinks cannot require me to sign the Authorization to receive treatment.
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
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. If re-disclosure occurs, I understand that Familylinks and its staff/employees have no responsibility or liability as a result of the redisclosure.
Drug and Alcohol Records
In accordance with 4 Pa Code 255.5 (b), Drug & Alcohol treatment information to be released shall be restricted to the following: 1) Whether the client is or is not in treatment 2) The prognosis of the client 3) The nature of the program 4) A brief description of the progress of the client 5) A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.
Information Specific to Release of Drug and Alcohol Records: I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. A general authorization by the release of medical or other information is not sufficient.

A copy of this authorization must be provided to clients when authorization is initiated by Familylinks and any authorization for drug and alcohol record releases.	
☐ Copy provided to client	☐ Copy refused by client

Signatures		
Client or Parent/Legal Guardian Signature	Date	Relationship
If you are signing as a personal representative of an individual, please describe your authority to act for this individual		
Staff Witness Signature	Date	
☐ Check here if client refused to sign authorization.		

Oral Authorization (for persons physically unable to sign)
Not Applicable to HIV Related Information or Drug and Alcohol Treatment Information

I witness that the client understood the nature of the release and freely gave oral authorization (Two witnesses are required)

Witness #1		Date of signature	
Witness #2		Date of signature	