Family Perspectives, L.L.C

Authorization for Release of Information

I, _____ _____
Name date of birth

authorize Family Perspectives, L.L.C./ Kim Romen to release the information described below to: _____
Person and agency (recipient)

_____
Address/ phone #

Information to be disclosed, **check all that apply:**

☐ Clinical Assessment	☐ Psychiatric Evaluation	☐ Medications
☐ Diagnosis/Prognosis	☐ Treatment/Service Plans	☐ Test Results/Labs
☐ Discharge Summary	☐ Progress Notes	☐ AIDS/HIV Information
☐ Team Staffings	☐ Substance Abuse Information	

☐ Other (Specify) _____

Purpose for Disclosure: _____

I understand that at anytime, I may revoke this authorization by writing to Family Perpectives in keeping with Family Perspectives Policies and Procedures. The revocation will be effective except to the extent that action based on this authorization has already been taken. You are referred to the Family Perspectives Notice of Privacy Practices for further information regarding your rights under federal law (HIPAA: 45 CFR 160-164). Authorization will expire one year from this date.

_____ _____
Signature of Individual/Guardian Date

_____ _____
Other required signature (if applicable) Witness

Notice to Recipient: This information has been disclosed to you from records that Federal law protects. These records are not subject to redisclosure. Federal regulations (42 CFR Part 2) **prohibit** you from **making further disclosure of Substance Abuse information** without this specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.