Front St. Inc.

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH INFORMATION

Complete All Sections, Date, and Sign

I. I hereby voluntarily authorize Front St. Inc. to release and disclose information from my health record.

Client Name	Date of Birth

II. The information is to be exchanged between:

_____

Front St. Inc. facility name, address, contact phone, e-mail address

_____

Recipient Name/Organization/Facility, address, phone, e-mail address

III. The purpose or need for this disclosure is:

☐ Collaborative Treatment ☐ Family/Friend Communication ☐ Placement

☐ Community Referral ☐ Insurance/Money Management

☐ Other *(Specify)*_____

IV. The information to be disclosed from my health record: check appropriate box(es) below

☐ All information pertaining to my treatment

☐ Only information related to: ☐ Confirmation of Residency

☐ Basic Health Summary (verbal/written update)

☐ Treatment Plan ☐ Progress Notes

☐ Physicians Orders ☐ Medication Records

☐ Medical History

☐ Assessment (including Diagnosis)

☐ Alcohol/Drug Abuse Treatment/Referral

☐ Other (Specify) _____

☐ Only the period of events from _____ to _____

☐ Specific information not to be provided:

_____

V. I understand I may refuse to sign this Authorization. I understand my refusal will not affect my ability to obtain treatment or eligibility for benefits.

I understand that I may revoke this authorization, in writing, submitted at any time to the following address: **Front St. Inc. 2115 7th Avenue, Santa Cruz, CA 95062**, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one (1) year from the date of my signature unless a different expiration date or event is stated.

_____
Specify new expiration date
(if less than 12 months)

I understand I have a right to receive a copy of this authorization.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

Signature of Client or Personal Representative *(State relationship to client)*	Date
Signature of Witness / Job Title *(If signature of client is a thumbprint or mark)*	Date

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from an agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).