Patient Information Release Authorization
Valley Hope Association T-02 / 03-05

X I,_____ hereby authorize
(Name of Patient)

Dallas Uhrich-Halstead Valley Hope to release information
(Name of individual or organization making disclosure)

contained in my patient records to the individual(s) or organization(s) and only under the conditions listed below:

Name of person(s) or organization(s) to whom disclosure is to be made:

X

Specific type of information to be disclosed (as limited as possible):

Letters, phone calls, recommendations, progress in treatment, aftercare plans and discharge summary.

The purpose and need for such disclosure (as specific as possible):

To facilitate legal obligations.

Without expressed revocation, this consent expires on the following date, event, or condition:
One year from date signed.

This is to certify that I have given consent freely and voluntarily. I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records 42. C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time, except to the extent that action has been taken in reliance on it.

X Patient Signature:_____ Date: ____/____/____

Parent or Authorized
Guardian Signature:_____ Date: ____/____/____
(If patient is a minor / incompetent)

X Witness Signature:_____ Date: ____/____/____

_____ _____
Signature of VH Staff Member Releasing Information Date Information Released

Type of Information Released:_____

_____

Note to Patient
Valley Hope's treatment services to you are not contingent upon your decision to provide or withhold consent to release information.