I05

Better Life PARTNERS

AUTHORIZATION FOR RELEASE OF INFORMATION

HIPAA and 42 CFR Part 2 COMPLIANT RELEASE

Client's Name: _____ Date of Birth: _____

I hereby authorize and request **Better Life Partners Inc** to (check all that apply):

❑ Release Information to ❑ Obtain Information from

with the following organization/individual:

Organization/Individual Name: _____

The following information is requested to be shared:

❑ **All** ❑ **Only those items which are pertinent to this referral**

❑ Office Notes	❑ Intake Assessment	❑ Urine Drug Test Results
❑ Psych/Social/Emotional Evaluation	❑ Medications	❑ Treatment Plan
❑ Counselor Reports	❑ Summaries	❑ Discharge Summary

Reason for Request: _____

Date range of records to release (check one): ❑ All dates ❑ Only from _____to_____

Form of Disclosure (check all allowed): ❑ Written ❑ Verbal ❑ Electronic

Read and Initial all statements below:

_____ Release of confidential information is subject to State and Federal Laws. By signing this release, I acknowledge my permission to release the above information to and/or from the individual or agency I have named which may include drug and alcohol abuse information. ***NOTE: Federal regulations govern the confidentiality of alcohol and drug dependent persons (42CFR Part 2). Federal Law prohibits the disclosure of (1) psychotherapy notes, (2) information compiled in reasonable anticipation, or for the use in civil, criminal, or administration action or proceedings.***

_____ I understand I may revoke this authorization at any time by notifying **Better Life Partners Inc,** in writing, except to the extent that: a) action has been taken in reliance on this authorization; or, b) if this authorization is obtained as a condition or obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

_____ I understand I have a right to request and receive a **Notice of Privacy Practices** for Better Life Partners Inc

_____ All releases expire one year from the date signed, unless otherwise indicated. Expiration date:_____

_____ I hereby authorized the following (please initial all applicable):

_____ Disclosure of the results of urine drug screens.

_____	_____	_____
(Signature of Client)	(Client's Name Printed)	(Date)
_____	_____	_____
(Signature of Witness)	(Witness Name Printed)	(Date)