AUTHORIZATION FOR OBTAINING/RELEASING INFORMATION

Client Name	Date of Birth
Client Address	Client Phone Number

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. In accordance with New York State Law and Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to Alcohol and Drug Treatment and Mental Health Treatment, except psychotherapy notes, only if these items are **initialed** under #12. In the event the health information described below includes any of these types of information, and I have **initialed** them under #12, I specifically authorize release of such information to the person(s) indicated on this release.
2. If I am authorizing the release of mental health treatment information, I understand that there is potential that the recipient may re-disclose this information without my authorization but that this will void the responsibility of Astor's authorization.
3. If I am authorizing the release of alcohol, drug or substance treatment, I understand that 42 CFR Part 2 federal law restricts this information from being re-disclosed by the recipient without my further consent.
4. If I wish to authorize the release of Confidential HIV-Related Information, I am required to complete a separate HIV-Related authorization form in order for this information to be released/obtained.
5. This authorization does not approve Astor to verbally discuss or email my information with anyone other than the person/agency noted below under 13A & B.
6. This authorization is valid until I have been discharged from the program, I turn 18 years of age or I revoke this authorization.
7. I may revoke this authorization at any time by written request (except for information already disclosed) to be delivered to Astor. This revocation will be recorded in section 17 below.
8. I understand that in order to protect the confidentiality of records, my agreement to release or obtain information is necessary and that this permission is limited to the purposes and to the persons/agencies listed below. While not a required condition for treatment.
9. I understand that signing this authorization is voluntary; my treatment, payment, enrollment in your programs or eligibility for services will not be conditioned based upon my authorization of disclosure.
10. I authorize Astor to ☐ release and/or ☐ receive information with the following:

11. Name of person, health provider or agency to release/receive this information to/from:

Address	Phone Number

12. Specific information to be released/received **(initial** next to each applicable information item):

_____Social History	_____Academic Information/School Behaviors	_____Discharge Summary
_____Intake Forms	_____Psychological Evaluation/Testing	_____Treatment Plan/Reviews
_____Psychiatric Evaluation	_____Physical Health Information	_____Medication Information
_____Alcohol/Drug Treatment	_____Other: _____	_____Other: _____

13a. Authorization to Verbally (In-Person or Telephone) Discuss Protected Health Information:
By initialing here_____I authorize Astor to verbally discuss my health information with the people listed below.

13b. Authorization to email and Discuss Protected Health Information**:** ☐ Yes ☐ No

If yes, by initialing here_____I authorize Astor to email and discuss via email my health information with the people listed here. Astor uses reasonable means to protect the security and confidentiality of email information sent and received. However, this protection cannot be guaranteed. Astor is not liable for improper disclosure of confidential information that is not caused by Astor's intentional or negligent misuse.

_____

(Name or agency & email address (if approved) listed under #11 above)

14. This information is being released for the purpose of:

☐ Initial/Ongoing Care or Treatment ☐ Litigation ☐ Other: _____
☐ Treatment Planning ☐ Physician/Services Referral
☐ Assessment/Evaluation ☐ Or Follow up for Referral

15. All items above this line (on previous page) have been reviewed with me and my questions have been answered, in addition I have been provided a copy of this form.

_____	_____
Signature of Client or Legal Guardian	Date
_____	_____
If not client, name of person signing form	Authority to sign on behalf of client
_____	_____
Witness Signature	Date

16. Verbal consent verification by Astor Staff: This section verifies that all the items above #15 (on previous page) have been reviewed with the below named parent/guardian/client via telephone and the parent/guardian provided verbal authorization for such release. Witnesses must each initial items under #12 verified by the verbal authorization.

Verbal authorization was received from _____ on _____ at _____.
(parent/guardian/client name) (Date) (Time: hh:mm)

_____	_____	_____
Witness #1 Name	Witness #1 Signature	Date
_____	_____	_____
Witness #2 Name	Witness #2 Signature	Date

17. Revocation of Authorization to Release of Information:
Complete this section only if you wish to revoke this authorization: Any information released prior to this signature date is waived from this revocation. If signed below, I revoke the authorization of release of information on the revocation date noted:

_____	_____
Signature of Client or Legal Guardian	Revocation Date
_____	_____
Client/ Name	Authority to sign on behalf of client
_____	_____
Witness	Date

Directions for completion of this form:

1. This form must be completed in its entirety in PEN or it is not valid.
2. Client name, Date of Birth, Address and Phone number are required at the top of the form.
3. A parent/guardian/client over 18 years of age (approved parties) must complete this form.
4. One of these approved parties must check one or both of the boxes under #10.
5. The Agency and/or name of person to release or obtain this information must be filled in under #11; this must include address and phone number.
6. Items under #12 must be **INITIALIED** by parent/guardian/client over 18 years of age **(or witnesses if verbal authorization)** in order for the information to be released.
7. 13a is required to be completed
8. 13b is an optional authorization to email and the applicable email address or domain must be placed on the line. Ex. ndauley@astorservices.org or a parent can note “all astorservices.org email addresses)
9. At least one box under #14 must be checked in order for this form to be valid.
10. All sections of item #15 must be filled in completely and legibly; signature, printed name, authority to sign (ie; mother, father, etc), date, witnesses and witness date all must be completed.
11. If Authority to sign on behalf of client is a Power of Attorney then the Power of Attorney documents must be received prior to this authorization being completed.
12. For verbal authorization: All sections of item #16 must be filled in completely and legibly (name of person giving verbal authorization, date, time given; witness names, signatures & dates).
13. If the parent/guardian/client over 18 years of age wishes to revoke this authorization then all items under #17 must be completed.
14. If all items on this form are not completed then the form will be returned to the witness for corrections; it is then the responsibility of the witness to contact the parent/guardian/client over 18 years of age to have the authorization corrected.