**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, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFINDENTIAL HIV-RELATED INFORMATION** only if I or my authorized representative **initial** these items under #11a. If **initialed** under #11a, I or my authorized representative specifically authorize release of such information to the person/agency indicated in #10.
2. If I or my authorized representative are authorizing the release of alcohol and drug treatment, mental health treatment or HIV-related information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. This authorization does not allow Astor to verbally discuss or email information with anyone other than the person/agency noted below.
4. This authorization is valid until the client has been discharged from the program, the client turns 18 years of age (if client was a minor at admission), or I or my authorized representative revokes this authorization. At age 18, Astor will update this authorization based upon the client's direct authorization.
5. I or my authorized representative may revoke this authorization at any time by written request or by completing a revocation of authorization for obtaining/releasing information (does not apply to information already disclosed).
6. I or my authorized representative understand that signing this authorization is voluntary; treatment, payment, enrollment in Astor's programs or eligibility for services will not be determined based upon my authorization of disclosure.
7. The information disclosed under this authorization may be redisclosed by the recipient (except as noted in #2 above), and this disclosure may no longer be protected by federal or state law.
8. This authorization does not authorize Astor to discuss my health information or medical care with anyone other than the attorney or governmental agency specified in # 12c.
9. I or my authorized representative authorize Astor to ☐ release and/or ☐ receive information with the person/agency noted below:

10. Name of person or agency to release/receive this information to/from:

| Address | Phone Number |
|---|---|

11a. I authorize the disclosure of information relating to:
☐ Mental Health Treatment, *excluding psychotherapy notes* (must **initial** here) _____
☐ Alcohol/Drug Treatment (must **initial** here) _____
☐ HIV-Related Information (must **initial** here) _____

11b. Information to be released/received:
☐ Entire record
OR
Specific information:

| | | |
|---|---|---|
| ☐ Social History | ☐ Academic Information/School Behaviors | ☐ Discharge Summary |
| ☐ Intake Forms | ☐ Psychological Evaluation/Testing | ☐ Treatment Plan/Reviews |
| ☐ Psychiatric Evaluation | ☐ Physical Health Information | ☐ Medication Information |

☐ Other: _____

12a. Authorization to Verbally (In-Person or Telephone) Discuss Protected Health Information:
By **initialing** here_____ I or my authorized representative authorize Astor to verbally discuss my health information with the person/agency listed above.

12b. Authorization to Email/Fax and Discuss via Email Protected Health Information**:**
By **initialing** here_____ I or my authorized representative authorize Astor to email and/or fax, and discuss via email (if applicable), the client's health information with the person/agency listed above. Astor uses reasonable means to protect the security and confidentiality of email/fax 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.

_____
(email address and/or fax number of person/agency listed in #10 above)

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12c. Authorization to Discuss Health Information:
By **initialing** here _____ I authorize Astor Services to discuss my health information (specific to the information identified in this authorization) with my attorney, or a governmental agency, listed here:
_____

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

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

14. This authorization has been reviewed with me, or my authorized representative and any questions have been answered, in addition I or my authorized representative may request a copy of this form.

**Proof of identity must be verified. Please provide a copy of client/authorized representative's photo id, or obtain witness signature (below):**

_____ _____
Signature of Client or Authorized Representative Date

_____ _____
Name of person signing form Authority to sign on behalf of client

_____ _____
Witness Signature *(not required if photo id provided)* Date

Directions for completion of this form:

- This form must be completed in its entirety or it is not valid.
- Client name, Date of Birth, Address and Phone number are required at the top of the form.
- A client (over 18)/authorized representative (approved parties) must complete this form.
- One of these approved parties must check one or both of the boxes under #9.
- The agency and/or name of person to release or obtain this information must be filled in under #10; this must include address and phone number.
- Items under #11a must be **INITIALED** by client (over 18)/authorized representative in order for the information to be released.
- #12a is required to be completed.
- #12b is an optional authorization to email or fax. The applicable email address or fax number must be placed on the line.
- #12c is an optional authorization.
- At least one box under #13 must be checked in order for this form to be valid.
- All sections of item #14 must be filled in completely and legibly; signature, printed name, authority to sign (i.e. mother, father, etc.), and date. Witness and witness date must be completed if a photo id is not being provided.
- If all required items on this form are not completed, then the form will be returned for corrections.
- If the client (over 18)/authorized representative wishes to revoke this authorization, then a revocation of authorization for obtaining/releasing information should be completed.