Access Behavioral Health Services

Release of Information
Authorization for Disclosure

Client Name: DOB:

Client Home Address:

Phone: SS #:

Agency requesting or needing information:
Access Behavioral Health Services
1276 River St., Suite 100
Boise, ID 83702

I authorize the following person or business to release or disclose confidential information about me:

Purpose of Disclosure:

Type of information to be disclosed __X__Psychiatric _____Drug/Alcohol _____ HIV/AIDS

Description of information requested:

This authorization is good until ____**1 yr**_____.

I understand that I am under no obligation to sign this form and the person and/or organization listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan, or eligibility for healthcare benefits or my decision to sign this authorization. I understand that if the person and/or organization listed above are not healthcare providers, health plans, or healthcare clearinghouses that must follow the federal privacy standards that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information could be re-disclosed without my authorization.

I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization. I understand that I have a right to receive a copy of this authorization. Copy requested and received _____Yes No _____ I do not want a copy of this.

I release the person/agency disclosing this information from any liability arising from the release of information to the agency or person designated above. Federal rules prohibit further disclosure of this information unless expressly permitted by the written consent of the person to whom it pertains or otherwise permitted by 42 CFR Part 2.

_____ _____
Client or guardian (individual over 14 both must sign) Date

_____ _____
Witness Date