Authorization To Release / Obtain Confidential Information

Ozgur Akbas, LMFT
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www.seacoastfamilytherapy.com

Client Name:	DOB:

I _____ hereby voluntarily authorize Ozgur Akbas to:

☐ Obtain information from: ☐ Release information to: ☐ Have ongoing verbal communication with:

_____
(Name of person, facility, organization, etc.)

Street _____ City _____ State _____ Zip _____ Telephone _____ Fax _____

INFORMATION TO BE RELEASED / OBTAINED:

To be Released:

☐ Assessments	☐ Treatment Plan(s)	☐ Psychiatric Services
☐ Alcohol/Drug Abuse Information	☐ Discharge Summary	☐ Other (specify):

To be Obtained:

Behavioral Health Information:		Medical Information:
☐ Assessment	☐ Psychiatric Services	☐ Most recent history and physical
☐ Psychological Testing	☐ Psychiatric Consultation Report	☐ Medications
☐ Treatment Plan(s)	☐ Discharge Summary	☐ Lab Results
☐ Progress Notes	☐ Alcohol/Drug Abuse Information	

☐ School Records (specify):

☐ Legal Records (specify):

☐ Other (specify):

REASON FOR RELEASE:

☐ Care Coordination ☐ Discharge Planning ☐ Evaluation ☐ Verification of Services

☐ Other (e.g. Transfer, Transition Planning):

Dates of Service Covered by this Release: _____ to _____

By signing below I understand that:

- Information in my record related to alcohol and/or drug treatment is protected under federal regulations 42 CFR, Part 2, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
- Ozgur Akbas cannot ensure that the recipient will maintain confidentiality of the information I have authorized to be released. If the person or organization authorized to receive this information is not a health care provider or a health plan, or is not otherwise covered under the federal privacy regulations, the released information may be re-disclosed and will no longer be protected by federal privacy laws.
- This authorization will be honored unless revoked in writing. Revocation may be made at any time except to the extent that action has already been taken. To revoke an authorization, I need to notify Ozgur Akbas in writing.
- This authorization is voluntary, and I verify that I have been given the chance to ask questions and if asked, that I have received satisfactory answers to my questions.
- This authorization shall expire as follows (Check One):
  - ☐ One year from date of signature below
  - ☐ Upon reaching (Enter a specific date, condition, or event):

Client Signature _____ Date _____ Parent/Guardian Signature (if applicable) _____ Date _____

PLEASE SEND THE REQUESTED INFORMATION TO THE FOLLOWING LOCATION:

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