

Authorization To Release / Obtain Confidential Information

Ozgur Akbas

Licensed Marriage & Family Therapist

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Helping Individuals, Couples & Families Achieve Balance



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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:		
<input type="checkbox"/> Assessments	<input type="checkbox"/> Treatment Plan(s)	<input type="checkbox"/> Psychiatric Services
<input type="checkbox"/> Alcohol/Drug Abuse Information	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Other (specify):
To be Obtained:		
Behavioral Health Information:		Medical Information:
<input type="checkbox"/> Assessment	<input type="checkbox"/> Psychiatric Services	<input type="checkbox"/> Most recent history and physical
<input type="checkbox"/> Psychological Testing	<input type="checkbox"/> Psychiatric Consultation Report	<input type="checkbox"/> Medications
<input type="checkbox"/> Treatment Plan(s)	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Lab Results
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Alcohol/Drug Abuse Information	
<input type="checkbox"/> School Records (specify):		
<input type="checkbox"/> Legal Records (specify):		
<input type="checkbox"/> 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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