NATIONAL INSTITUTE FOR CHANGE

Authorization for Use or Disclosure of Protected Health information

(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

1. Release of Information
   a. ☐ I hereby authorize National Institute for Change to **DISCLOSE** protected information to the following agency as described below:
   b. ☐ I hereby authorize National Institute for Change to **RECEIVE** protected information from the following agency as described below:

Organization: _____	Address: _____
Phone: _____	Address: _____
Fax: _____	

2. I hereby authorize release of the following information (please check all that apply):

☐	Treatment	☐	Evaluation Results	☐	Treatment Attendance
☐	Clinical Progress	☐	Employment	☐	Lab Results
☐	Criminal Records	☐	Treatment Planning	☐	Monitoring Compliance
☐	Medication Assessment and Management				

3. This authorization shall be in force and effect until _____ or for 1 year, at which time this authorization expires.

4. I understand I have the right to revoke this authorization, in writing, at any time. I understand that revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization.

5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that my records are protected under the Federal Regulations governing Confidentiality of Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This consent automatically expires at the end of one year unless otherwise indicated below.

Client Signature: _____ Date: _____

Client Name (print) : _____ Date: _____

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

Staff Signature: _____ Date: _____

I hereby revoke this authorization effective _____

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____