FAMILY & CHILDREN'S SERVICES, INC.
AUTHORIZATION FOR DISCLOSURE/RELEASE OF PROTECTED HEALTH INFORMATION

Client Name: ____________________ Date of Birth: ______________ Client Number:_____________

I authorized Family & Children Services, Inc to ☒ disclose to and/or ☒ obtain protected health information that identifies me and to share my protected health information with the person/agencies below:

Name of Persons or Title of Persons or Organization: Social Security Law Center, LLC, ________________________
____.

Description of Information to be Disclosed or Shared (Check one or more boxes below)

- ☐ Assessment
- ☐ Diagnosis
- ☐ Psychological Evaluation
- ☐ Psychiatric Evaluation
- ☐ Treatment Plan or Summary
- ☐ Current Treatment Update/Care Plan
- ☐ Medication Management Information
- ☐ Attendance/Participation in Treatment
- ☐ Nursing/Medical Information
- ☐ Toxicology Reports/Drug Screens
- ☐ Educational Information
- ☐ Discharge/Transfer Summary
- ☐ Progress in Treatment
- ☐ Demographic Information
- ☐ Laboratory reports
- ☐ Client video, audio or photographs
- ☐ Physician Orders
- ☐ Psychotherapy notes (If checking this box, no other boxes can be checked)
- ☐ Other ___________________________

Description of Purpose for Disclosure (Check one or more boxes below)

- ☐ Improve assessment and treatment planning
- ☐ Share information relevant to treatment
- ☐ Coordination of treatment services
- ☐ Court proceedings or other testimony
- ☐ Participation in external sponsored activities
- ☒ Legal consultation
- ☐ Educational activities
- ☐ Promotion of F&CS programs or activities
- ☐ Licensure supervision
- ☐ Participation in research project
- ☐ Advocacy

If other purpose, please specify: ____

Expiration
Unless sooner revoked, this authorization expires on the following date: one year from date of signature (Not longer than one (1) year).

Form of Disclosure
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically. If you are requesting access to your own information, we will produce it in an electronic format that you request if it is readily producible in that format, or if not, in a different electronic format on which we can agree.

I understand not all email is secure and individuals not authorized by me may be able to access my protected health information if this information is sent by email.

Acknowledgements
I understand that this authorization is voluntary and I may refuse to sign this authorization to release or obtain my records. The refusal will have no effect on received services from Family & Children Services. I understand that I have the right to inspect the health information to be released and that I may refuse to sign this authorization.

I understand that records requested may be protected under federal regulations (42 C.F.R., Part 2, and HIPAA), and state confidentiality laws and regulations and cannot be released without my consent unless otherwise provided for by these regulations and laws.

I understand that any drug and alcohol abuse records are confidential and will not be released without my express written consent unless the situations discussed in the "Notice of Confidentiality of Alcohol and Drug Abuse Patient Records," which I have received , occur.

I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released protected health information may no longer be protected by federal privacy regulations (HIPAA) and may be subject to redisclosure.

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Family & Children Services Medical Records. I understand that I cannot restrict information that may have already been shared based on this authorization.

FURTHER, THE PHI AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICHMAY INDICATE THE PRESENCE OF COMMUNICABLE OR NONCOMMUNICABLE DISEASE. I FURTHER UNDERSTAND THAT MY PHI MAY INDICATE THAT I HAVE BEEN TREATED FOR PSYCHOLOGICAL OR PSYCHIATRIC CONDITIONS.

Signature
If the client is a minor, and the treatment provided is related to evaluation related to substance abuse, diagnosis or treatment of a communicable disease, pregnancy, this form must be signed by that minor, rather than the parent or legal guardian. If a minor is married, has court order of emancipation, or lives apart from or is not supported by his or her parents or guardian, this form may be signed by the minor alone.

____ __________________________________
Signature of Patient/Client Date

____ ___________________________________
Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare proxy, or guardian, etc.)

____
Capacity of Legal Representative (if applicable)

☐ Staff check here if client refuses to sign authorization

Notice of Redisclosure
Federal law prohibits the person or organization to whom disclosure is made from making any further disclosures of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R., Part 2. I will be given a copy of this authorization for my records