

**AUTHORIZATION AND CONSENT TO RELEASE MEDICAL
INFORMATION
PSYCHIATRIC/PSYCHOLOGICAL/MENTAL HEALTH**

Patient Name: _____ Birthdate: _____
Address: _____
SS#: _____

Dates of treatment to release: All Specific
Dates: _____

I authorize **DIAKONOS, INC. d/b/a DIAKONOS COUNSELING** to release the above patient's medical information to: *(provide address)*:

This information is to be released for the purpose of:

(Medical records, including psychiatric, psychological and mental health records, frequently contain confidential remarks furnished by the patient, patient's family and staff. If, in the judgment of the medical staff, disclosure of such information will be harmful to the patient, release of such information may be withheld.)

I understand that the records released may contain alcohol and drug treatment, AIDS/HIV or mental health information. I understand this communication will reveal the patient's presence as a patient in a treatment facility.

This Authorization and Consent to Release demonstrates compliance with the Health Insurance Portability and Accountability Act ("HIPAA") Standards for Privacy of Individually Identifiable Health Information ("Privacy Standards"), 45 CFR 160 & 164 and Federal Regulations 42 CFR Part 2 and all federal regulations and interpretive guidelines promulgated thereunder. The recipient of this information may not disclose this information unless another authorization is obtained from the patient or unless such disclosure is required or permitted by law (42 CFR Part 2). I understand once the requested information is disclosed, the HIPAA Privacy Regulations may no longer protect it should the recipient re-disclose it.

I understand that my health care provider generally may not condition health care services upon my signing an authorization unless the health care services are provided to me for the purpose of creating health information for a third party.

I authorize the above named person/organization and/or members of their staff, to furnish the above information, including photostatic or faxed copies of my medical records to the above named organization or to its agents. By authorizing the release of records indicated, I acknowledge and agree **Diakonos, Inc. d/b/a Diakonos Counseling**, and their agents, representatives and attorneys, will not be liable for any consequences which result or may result from the disclosure of the patient's records in accordance with this Authorization and Release.

I understand that I may revoke this Authorization and Release in writing at any time, except to the extent that action has been taken in reliance thereon. In any event, upon fulfillment of the above-stated purpose, this document will automatically expire:

90 days 180 days one year other _____ from the date signed.

Patient Signature: _____ Date: _____

Print Name: _____

Parent/Guardian Signature/Representative: _____ Date: _____

(If the authorization is signed by a personal representative of the patient, such as a parent or guardian, a document authorizing such representative's authority to act for the patient must be provided.)

Witness Signature: _____ Date: _____