Conifer Park Authorization to Release Information

Patient Name ______ Admit Date ______ DOB ______ Patient # ______

I do hereby consent and authorize Conifer Park, Inc. to obtain information from and release to:

Organization Name ______

Contact's Name ______ Job/Position ______

Address ______ Suite / Apt # ______

City ______ State ______ Zip Code ______

Phone # *(inc. area code)* ______ Fax# *(inc. area code)* ______ Email ______

I authorize Conifer Park, Inc. clinical, medical, administrative and clerical personnel to release information about me as follows:
The following information pertaining to this admission:

- ☐ Presence in treatment (admit/discharge dates)
- ☐ Medical history and physical examination
- ☐ Results of diagnostic tests and testing
- ☐ Psychiatric/psychological consults
- ☐ Educational records, achievements, assessments
- ☐ Other ______
- ☐ Psychosocial/diagnostic summary
- ☐ Diagnosis/prognosis
- ☐ Treatment plan
- ☐ History and behavior related to diagnosis
- ☐ Immunization records
- ☐ Educational discharge summary
- ☐ Description of progress in Tx
- ☐ Discharge summary
- ☐ Continuing care plan
- ☐ Legal history

This information is needed for the following purposes to:

- ☐ Provide ongoing treatment/continuing care
- ☐ Provide educational services
- ☐ Coordinate continuing care efforts w/ employer
- ☐ Coordinate Tx w/ family or concerned persons
- ☐ Enable judges, attorneys, probation/parole officers to support Tx goals/make legal decisions
- ☐ Obtain insurance, employment, gov't benefits
- ☐ Coordinate services w/ authorized school officials
- ☐ Coordinate educational planning/re-entry program with school persons
- ☐ Other ______

I understand that I need not consent to the release of information in order to obtain services. I choose to do so willingly and voluntarily for the purpose(s) specified above. The duration of this authorization is for this admission, and no longer than 120 days unless I specify a date, event or condition upon which it will expire sooner. I understand that I may revoke this authorization at any time by notifying Conifer Park Department of Health Information Management in writing, except to the extent that action has been taken in reliance on my authorization. I understand that I will be expected to pay .75/page for copies of records sent for purposes other than to provide for continuing care.

***SIGNATURES**: Please specify date, event or condition upon which authorization expires sooner than 120 days from signing*

Patient ______ Date ______

Parent/Legal Guardian ______ Date ______

Legal Representative ______ Date ______

Witness ______ Date ______

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Additionally, these records are protected by 45 CFR Parts 160 and 164 (HIPAA).