AUTHORIZATION TO RELASE OR EXCHANGE CONFIDENTIAL INFORMATION

SANCTUARY
COUNSELING & PSYCHOLOGICAL TESTING

4737 AFTON PLACE, STE A, CHUBBUCK, IDAHO 83202 PHONE: 208-417-0623 FAX: 208-417-0641

USE ONE SHEET PER PROVIDER/ CONTACT (ATTACH PHOTO ID)

TODAYS DATE:_____/_____/_____

PATIENT LEGAL NAME:_____ DOB:_____

PRIMARY CARE PROVIDER/ MEDICAL CLINIC: _____

PHYSICIAN NAME: _____PHONE:_____

ADDRESS: _____ FAX:_____

CLINIC/ DATE FAXED:_____/_____/_____ WITNESS INITIALS:_____

OTHER PROVIDER/ PERSONAL CONTACT: _____ PHONE:_____

NAME:_____ RELATIONSHIP:_____ FAX:_____

PLEASE INITIAL EACH CATEGORY OF SPECIFIC INFORMATION THAT YOU ARE ALLOWING TO BE RELEASED OR EXCHANGED. WRITE "NO" IN CATEGORIES OF THAT YOU ARE NOT ALLOWING TO BE RELEASED.

_____ 6 MONTH MEDICAL HISTORY & RECORDS _____ VERBAL COMMUNICATION AS NEEDED

_____PSYCHOLOGICAL EVALUATION _____ CDA/ TREATMENT PLAN(S)

OTHER:_____

(CHECK BOXES) THIS INFORMATION IS BEING RELEASED OR EXCHANGED FOR THE FOLLOWING PURPOSE(S):

☐ COORDINATION OF TREATMENT/ CARE ☐ FAMILY CONSULTATION ☐ OTHER_____

☐ I DECLINE GIVING SANCTUARY COUNSELING MY MEDICAL INFORMATION.

PRINTED NAME OF CLIENT/PATIENT_____ ☐ SELF ☐ PARENT/ GUARDIAN

SIGNATURE OF CLIENT/ GUARDIAN_____ RELATIONSHIP_____

CLINIC WITNESS:_____ TITLE:_____

***THIS RELEASE EXPIRES ONE YEAR FROM THIS DATE: ____/____/_____** **REVISED 03-01-2023**

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42) CFR Part 2 prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical, or other information is not sufficient for this purpose.