FAMILY SERVICE OF THE CHAUTAUQUA REGION INC
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CONSENT TO *DISCLOSE* PROTECTED HEALTH INFORMATION

I, _____ (Birth Date) _____,
(Please print client name)

authorize Family Service of the Chautauqua Region, Inc. to disclose my protected health information to:

_____
(Please print name of person or agency/ contact information)

The purpose of this release of information is:

____To Coordinate care/treatment ____ To comply with court or probation conditions ___ To make referral

___ Other (specify) _____

The information to be released is for all dates of service unless specified here:_____ and includes the following:

___ Diagnosis ___ Medical Records ___ Billing & Payment Information ___Verbal Exchange of information

___ Academic and/or educational needs ___Treatment planning/recommendations

___ Psychological testing/assessment reports ___ HIV-Related Information ___ Legal Records

___ Presence in Treatment ___Drug & Alcohol Information

___ Other (specify) _____

This authorization expires when I am discharged from this treatment episode unless otherwise specified here: _____*(After that date, no more information can be released unless a new Authorization is signed.)*

I understand that I do not have to agree to release information in order to receive treatment from Family Service.

Information released by Family Service is protected health information. The recipient named above is prohibited from re-disclosing such information without my permission to do so..

I can cancel this authorization at any time *in writing*. No information will be shared from that date forward.

I would like a copy of this form. □ **Yes**

I acknowledge that: I have read this form and understand its contents. I am the patient, or person duly authorized either by the patient or otherwise, to sign this consent and accept its terms.	
Signature of Client (age 12 and older)	Date
Signature of Parent/Legal Guardian	Date
Witness (Staff Signature)	Date

September 2023