



**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

<b>Patient Name:</b>	<b>Patient Date of Birth:</b>
<b>Patient Telephone:</b>	<b>Patient Last 4 of SSN (optional):</b>
<b>Person or Organization Authorized to Release the Protected Health Information:</b>	<b>Person or Organization Authorized to Obtain the Protected Health Information:</b> Careteam Plus, Inc.
<b>Address:</b>	<b>Address:</b> 100 Professional Park Drive Conway, SC 29526
<b>Phone Number:</b>	<b>Phone Number:</b> 843-234-0005
<b>Fax Number:</b>	<b>Fax Number:</b> 843-234-8235

**Records to be released should include:**

Description	Date(s) of Service	Description	Date(s) of Service:
<input checked="" type="checkbox"/> Progress Notes	Last 2 years	<input checked="" type="checkbox"/> Immunization History	All available
<input checked="" type="checkbox"/> Laboratory/Pathology Results	Last 2 years	<input type="checkbox"/> Billing Records	
<input checked="" type="checkbox"/> Diagnostic Imaging	Last 2 years	<input type="checkbox"/> Case Management records	
<input checked="" type="checkbox"/> Consultation Reports	Last 2 years	<input type="checkbox"/> Other:	
<input checked="" type="checkbox"/> Medication Lists	Last 2 years		

Specific purpose: \_\_\_\_\_ Continuity of care \_\_\_\_\_

I hereby request and authorize the above named agency, organization or individual which possesses information relative to the client named above to release/exchange information, as specified, to/from the agency, organization or individual named on this request. I understand that the information to be released/exchanged may include information about substance abuse, psychological or psychiatric impairments, and HIV/AIDS. This information may be transmitted electronically through fax or the Provide database system. **I UNDERSTAND THAT INFORMATION TRANSMITTED BY FAX IS NOT GUARANTEED TO REMAIN CONFIDENTIAL.** I understand that any information transmitted may not reach its intended destination and could reach any type of destination. I understand my right to confidentiality is protected under federal and state law. I acknowledge that my signature on this form is voluntary and valid. Signing this authorization, releases this facility and its employees from any legal responsibility as a result of any information being transmitted by fax. I understand that a copy or fax of this authorization is as effective as the original.

I understand that my records are protected under Federal regulations governing Confidentiality of Alcohol and Drug Use Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time by dating and signing the revocation below, except to the extent that action based on this authorization has been taken. I understand my refusal to give authorization in no way jeopardizes my right to obtain present or future services.

<b>I have read the above and authorize the disclosure of protected health information as stated.</b>	
<b>Patient's Signature:</b>	<b>Date:</b>
<b>Parent/Guardian/Representative Signature:</b>	<b>Date:</b>
<b>Relationship to Patient:</b>	
<b>Witness Signature:</b>	<b>Date:</b>

This Authorization will expire in **365 days** unless otherwise specified below:

Expiration Date: \_\_\_\_\_ I chose to revoke this consent effective: \_\_\_\_\_

Patient/Parent/Guardian Representative Signature to request revocation: \_\_\_\_\_