AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

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

Records to be released should include: (INITIAL EACH)

Description	Date(s) of Service	Description	Date(s) of Service:
☐ Progress Notes		☐ Immunization History	
☐ Laboratory/Pathology Results		☐ Billing Records	
☐ Diagnostic Imaging		☐ Case Management records	
☐ Consultation Reports		☐ Other:	
☐ Medication Lists			

Specific purpose:____

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.

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

This Authorization will expire in **90 days** unless otherwise specified below:

Expiration Date:____________________ I chose to revoke this consent effective:__________________________________

Patient/Parent/Guardian Representative Signature to request revocation: ____