CORNERSTONE

Psychological Associates, PLLC

1755 Westgate Dr., Ste. 260, Boise, ID 83704 ♦ (208) 373-0790 ♦ FAX (208) 373-0816

Authorization for Release of Confidential Information

Re: Patient Name:_____**D/O/B:**_____

Address: _____**Phone:**_____

I, _____**, authorize**_____ **@ Cornerstone Psych Assoc, PLLC**

to ☐ disclose to, or ☐ to request from: Name: _____**Phone:**_____

Address:_____**Company/Title:**_____

These records concern the DATES between_____**and**_____ **OR ☐ All Dates**

The following information:	**OR, mark one or more of the following:**
☐ All Mental Health Records	☐ Mental Health Record Summary ☐ Psychological Evaluation ☐ Psychotherapy Notes ☐ Other (Specify) _____

The purpose or need for such disclosure:

☐ Ongoing Treatment ☐ Coordination of Care ☐ Legal Issues

☐ Other (Specify) _____

I understand that my records are protected under Federal and State confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that the information disclosed pursuant to this authorization may potentially be re-disclosed by the recipient and may no longer be protected by state and federal privacy laws.

The information authorized for release may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42CFR part2). The Federal rules prohibit anyone receiving this information or record from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or is otherwise permitted by 42CFR part 2. A general authorization for the release of medical 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. As a result, by signing below, I specifically authorize any such records included in my record to be released.

I also understand that I may revoke this consent in writing at any time, except to the extent that action based on it has already taken place, by contacting the Clinic at the address above. This consent automatically expires 6 months after my termination from the Clinic's program

I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

This consent is in effect until one year from date of signature, or as specified_____. I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

_____ **Date** _____

Patient Signature - age 14 and older

_____\ _____ **Date**_____

Parent / Guardian Signature - (if patient is a minor) **(Relationship)**