VALIDATION RESILIENCE PEACE
HOPE TRUTH EMPOWERMENT FAITH SAFETY
FOUNDATION
FOR HEALING, LLC

"Building Recovery From the Ground UP"

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

I understand that these records may contain information pertaining to alcohol or substance abuse and/or HIV/any communicable disease testing or treatment. I authorize Foundation for Healing, LLC to release to/receive from or exchange Protected Health Information listed below with:

Legal Printed Name:_____D.O.B._____

To/From: Name/Organization: _____ Relationship: _____

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Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____Cell ____ Work ____ Home_____ Secondary:_____

May we Contact this number via: Voice Call (Y) _____ (N) _____ Text (Y) _____(N) _____ Leave a Message (Y) _____ (N) _____

E-Mail: _____ Secondary: _____

To/From: Name/Organization: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____Cell ____ Work ____ Home_____ Secondary:_____

May we Contact this number via: Voice Call (Y) _____ (N) _____ Text (Y) _____(N) _____ Leave a Message (Y) _____ (N) _____

E-Mail: _____ Secondary: _____

Reason for disclosure: Coordination of care: ____ Evaluation/ Treatment: ____ Records Release: ____ Applying for Benefits: _____ Legal:_____

Emergency Contact: _____ Other (specify):_____ _____

This information may be written, verbal or both. I hereby release any and all legal liability that may arise from the disclosure of the information, and certify that I have made this request freely and voluntarily. I further understand that Foundation for Healing, LLC will not require my signing of this authorization a condition or denial of my treatment. I understand that disclosure to a third party, may no longer be protected by the federal privacy regulations and may be re-disclosed by the person or organization that receives the information.

***I understand that I may revoke this authorization in writing, at any time ***

This release expires **one year from date of signature** or on the prior date of: _____

_____ _____
Signature of Client or Personal representative Date Signed

_____ _____
Witness Signature Date Signed

Created by: dmj 6.1.2020