AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

In compliance with Federal Statutes and Regulations (42 U.S.C. § 4582 and 42 U.S.C. § 290dd-2 and 290ee-3 and 42 C.F.R. § 2), the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (45 C.F.R. Pts. 160 and 164), and 16 *Del. C.* ch. 12.

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

I, the undersigned, hereby authorize _____
(*name and address of person/agency/organization*)

☐ To release information to: ☐ To obtain information from:

Name of Agency/
Person/Organization: _____

Mailing Address: _____

City, State, ZIP Code: _____

Information to be released includes (please initial):

_____ Summary of Treatment
_____ Psychosocial History
_____ Psychiatric/Psychological Evaluation
_____ Medical History
_____ Substance Abuse History
_____ Medication Record
_____ HIV/STD
_____ Laboratory Results
_____ Other (specify) _____

For the Treatment Period of: _____

The purpose or need for this disclosure is (*be as specific as possible*): _____

_____

This consent extends from the date of signature below for a period of:

_____ 60 days

_____ Other (specify) _____

I understand that my records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 and 164 and 16 *Del. C.* ch. 12, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it. I understand that my private health information, once disclosed to others, may be redisclosed to individuals or organizations not subject to HIPAA and may no longer be protected by HIPAA. This release expires in 60 days from the date of execution of this release unless otherwise specified.

Date: _____ Signed: _____

_____
(*identify relationship if other than the patient*)

Date: _____ Signed: _____
(Witness)