2165 Hampton Ave.
St. Louis, MO 63139
(314) 646-7500
Fax: (314) 646-8181

RELEASE OF INFORMATION

Sending/Receiving Information

Safe Connections is committed to protecting the privacy of all clients as completely as possible. However, in some cases, it is important for us to share information with others. This authorization complies with the HIPAA (Health Insurance Portability and Accountability Act) Privacy Rule and allows health care providers and other professionals to share personal health information.

I, ____ (client name)

Client Birth Date ______________________ Social Security Number _________________________

give Safe Connections permission to disclose/receive the following specified information from my records (check all that apply):

- ☐ Assessment/Evaluation Summary
- ☐ Closing/Discharge Summary
- ☐ Consultation Notes
- ☐ Group Notes
- ☐ Medication Information
- ☐ Other (be specific): ____________________________________
- ☐ Progress Notes
- ☐ Psychiatric Evaluation
- ☐ Psychiatric Records
- ☐ Treatment Plan

Dates of Service for records to be received/released:

FROM (date) _______________________ TO (date) ______________________________

Check which applies: ☐ **Disclosure/release TO: (below)** ☐ **Receive FROM: (below)**

Name:____

Agency/Organization:____

Address:____

Phone:_________________________ Fax:_________________________

The purpose of this disclosure is: (check all that apply)

- ☐ Assessment
- ☐ At Client's Request
- ☐ Changing Mental Health provider
- ☐ Continuity of Services/Care
- ☐ Consultation
- ☐ Eligibility Determination
- ☐ For personal access
  - ☐ Copy
  - ☐ Review
  - ☐ Summary
- ☐ Other (specify): _________________
  ____

The release of this information may be made by mail or fax. By signing this release, I admit that any earlier agreements I have made to limit my personal health information do not apply to the information released under this agreement.

I understand that my medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of my medical/health information. The protected health information in my record includes mental/behavioral or medical health information. In addition, it may include information relating to sexually transmitted diseases, acquired immunodeficiency virus (AIDS), human immunodeficiency virus (HIV), other communicable diseases, and/or alcohol/drug abuse.

Alcohol and drug abuse information records are specifically protected by federal regulations (42 CFR 2) and by signing this authorization I am allowing the release of the specified alcohol and/or drug information, if any, in my records indicated on side one of this release to the agency/person listed above.

RE-DISCLOSURE

I understand that information received by Safe Connections in accordance with this authorization may not be re-disclosed to a third party. I also understand that Safe Connections is not responsible for possible re-disclosure of any information provided to an outside party in accordance with this authorization.

EXPIRATION

Information may be released:

( ) one time only

( ) for a limited time period of: (circle one) 90 days / 6 months / 1 year

This permission for the release of information can be removed at any time, except when action has already been taken. In any event, this release will expire on the date listed above.

By signing this release I am allowing Safe Connections to send or receive my personal information. I have read and understand this authorization. Safe Connections has my permission to accept a facsimile (fax) or photocopy of this release, the same as an original.

Client Signature ____ Date___________________

Parent/Guardian Signature____________________________________ Date ___________________

Witness Signature ____ Date ___________________

REVOCATION OF CONSENT

I am exercising my right to revoke my consent allowing Safe Connections to release any of my records or personal information. Although I understand that I cannot do anything about information already disclosed under this authorization, I do not want any more information disclosed.

Client Signature ____ Date_____________________

(sign for revocation purposes only)

Witness Signature ____Date ____________________

PROHIBITION OF REDISCLOSURE: Persons, agencies, or institutions to whom this information is disclosed are prohibited by state/federal law from redisclosures without the written consent of the person to whom it pertains.