Guinn . . . dedicated to helping the people we serve have a better life

HEALTHCARE TECHNOLOGIES, LLC

Authorization to Release Confidential Information

I authorize Guinn Healthcare Technologies, LLC to disclose to and receive from:

☐ Person/organization: (List name, address)

☐ Person/organization: (List name, address)

the following information:

- ☐ my name and other personal identifying Information
- ☐ initial evaluation
- ☐ date of admission
- ☐ assessment results
- ☐ summary of treatment plan
- ☐ Other: (list)
- ☐ progress and compliance with treatment attendance
- ☐ date of discharge and discharge status
- ☐ discharge plan
- ☐ employment and training related information

The purpose of these disclosures is to enable the identified entities to provide or receive information related to assisting with treatment, evaluating and responding to participation and progress, determining my readiness/ability to participate in work, or other purposes. [Describe: ____]

For Substance Abuse Clients: I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that, except for action already taken, I may rescind this consent at any time. If I do not rescind this consent, it expires automatically as follows:

- upon my termination from Guinn Healthcare Technologies, LLC Mental Health and Social Services Programs or three years from the date this consent is signed (whichever comes first)

For Mental Health Clients: I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I also understand that, except for action already taken, I may rescind this consent at any time. If I do not rescind this consent, it expires automatically as follows:

- upon my termination from Guinn Healthcare Technologies, LLC Mental Health and Social Services Programs or three years from the date this consent is signed (whichever comes first)

____ ________________

CLIENT SIGNATURE DATE

____

CLIENT SOCIAL SECURITY #

____ ________________

STAFF SIGNATURE DATE

____

END DATE (consents will expire 3 years from the date of client signature unless otherwise indicated)

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42CFR Part 2) prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose.