Safe Harbor Metro Region — Authorization for Release/Request of Information

CORNERSTONE

Client Name ____ Date of Birth _______________

I Authorize:

____
Safe Harbor Agency/Other Organization

____ __________________________
Address/City/State/Zip Phone/Fax

☐ **To RELEASE Information TO:**
☐ **To RECEIVE Information FROM:**

____
Safe Harbor Agency/Other Organization

____ __________________________
Address/City/State/Zip Phone/Fax

Purpose of Released/Requested Information:

☐ Continuation of Care ☐ Coordination of Services ☐ Assessment ☐ Treatment Planning
☐ Referral ☐ Case Management ☐ Other: ____________________

Information to Be Released:

☐ Consultation	☐ Mental Health Records	☐ Treatment Plan
☐ Social History	☐ Educational Records	☐ Community Support Plan
☐ Presenting Situation	☐ Medication Notes	☐ Progress Report/Summary
☐ Discharge Summary	☐ Progress Notes	☐ **Any Necessary Information**

☐ Other: ____

Release Method Requested: ☐ Paper ☐ Fax ☐ Verbal ☐ Email: _________________________

- I understand that my health record may include information relating to mental or behavioral health, chemical dependency, child abuse, sexual exploitation/sex trafficking, and/or child protection or law enforcement information.

  I don't want the following records released: ____
- I understand that I may revoke this authorization at any time. I understand that if I stop this authorization, I must do so in writing to the location where I received service. I understand that stopping this authorization will not apply to information that has already been released or disclosed.
- I understand that authorizing the release of this information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal privacy rules.
- I understand that this information will be shared only with staff or their consultants whose work requires access to my data within the purposes specified above. Every effort will be made to preserve confidentiality of this information.
- **This authorization will end one year from the date the form is signed unless I indicate an earlier date or event here:** ____

____ ___________________
Client Signature Date Signed

____ ___________________
Parent/Guardian Signature Date Signed

Relationship to Patient: ___________________________________