Authorization to Disclose or Obtain Information

I, _____ (*Name of Client*), whose date of birth is _____/_____/_____,

authorize **Jewish Family Service Of The Desert (JFS)** to disclose to and/or obtain from:

_____ _____ _____

Name of Person or Title of Person or Organization Telephone # Fax #

_____

Address City/State Zip

the following information:

Description of Information to be Disclosed (Client to initial each item to be disclosed)

___ Assessment
___ Diagnosis
___ Psychological Evaluation
___ Psychiatric Evaluation
___ Treatment Plan or Summary
___ Current Treatment Update
___ Medication Management Information
___ Presence/Participation in Treatment
___ Nursing/Medical Information
___ Toxicological Reports/ Drug Screens
___ Educational Information
___ Discharge/ Transfer Summary
___ Continuing Care Plan
___ Progress in Treatment
___ Demographic Information
___ Legal documents
___ Other _____

Purpose
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If other purpose, please specify: _____

Revocation
I understand that I have the right to revoke this authorization in writing at any time by sending written notification to **JFS at 490 S. Farrell Dr., Suite C208, Palm Springs, CA 92262**. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
Unless sooner revoked, this consent expires on the following date ____/____/____ or as otherwise indicated below:

_____

Conditions

I further understand that Jewish Family Service of the Desert will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Re-disclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R Part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances:

I will be given a copy of this authorization for my records

_____ _____

Signature of Client Date

_____

Name of Parent, Guardian or Personal Representative

_____ _____/____/_____ _____

Signature of Parent, Guardian or Personal Representative Date Relationship

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.)

_____ ***Client declined to sign authorization.***

_____ ____/____/____

Signature of Staff Witness Date

Last Revision 7/8/15