Cognitive Assessment & Referral Services PLLC

RELEASE OF INFORMATION

Release Authorized by:

Name:	
Address:	
Phone:	

I hereby authorize:

Name:	
Address:	
Category:	

To obtain the information requested below with/from:

Name:	
Address:	
Category:	

Nature of information to be released:

Reason for Disclosure:

Written Revocation: I understand that I have the right to revoke this authorization at any time but must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Re-disclosure: I understand that once the health information is disclosed pursuant to this authorization, it could be disclosed by the recipient(s) and no longer be protected by the Health Insurance Portability and Accountability Act of 1996 and its regulations.

Substance Abuse Disorder: I understand that my substance abuse disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability Accountability Act of 1996. ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Each disclosure made with your written consent must be accompanied by the following written statement:

> This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

Patient Signature	Date
Guardian Signature (if applicable)	Date

This authorization will expire in 1 year from above date.