Authorization for Release of Client Information

CLIENT INFORMATION		
Client's Full Name:	Date of Birth	Enrollee Number (ID Code):

INFORMATION TO BE RELEASED TO / FROM	
Name of School:	Agency: **CLARK COUNTY SCHOOL DISTRICT**

INFORMATION TO BE RELEASED TO / FROM	
Name of Doctor:	Agency:

INFORMATION TO BE RELEASED TO / FROM	
Name:	Agency:

INFORMATION TO BE RELEASED TO / FROM	
Name: Larry Crawford	Agency: **NEW BEGINNINGS**

Purpose of this release is to secure, coordinate, and/or provide services for the above named client.

I understand that this information is being shared in collaboration with the service providers who are responsible for the treatment planning of my care.

This authorization for release of information is required for service provision by a contracted or cooperating service provider. Therefore this release will be effective from the date of signature through the timeframe specified below.

☐ **<u>One year</u> for child welfare only clients.**
☐ **<u>One year</u> for clients receiving mental health services.**
☐ **<u>90 days</u> for former providers.**

I authorize the release of the following information (Check all to be released):

☐ **<u>Identifying Information</u>**: name, birth date, social security number, sex, race, address and telephone number.

☐ **<u>Financial Information</u>**: Public assistance eligibility and payment information provided for establishing eligibility including but not limited to pay stubs, W2's and tax returns, and other financial information.

☐ **<u>Case Information</u>**: Please check type information to be released:

☐ Treatment Plan	☐ Independent Living Assessment	☐ Discharge Summary
☐ Social History	☐ Other Assessments	☐ Progress notes
☐ Diagnostic Assessment	☐ Individualized Education Plan	☐ Other: Specify
☐ Consultation Reports	☐ Multi-factored Education Inventory	☐ Other: Specify

<u>Drug and/or Alcohol Abuse and/or Psychiatric, and/or HIV/AIDS Records Release</u>

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and/or other sensitive information, I agree to its release. Check one: ☐ Yes ☐ No _____Initials

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment. I agree to its release. Check one: ☐ Yes ☐ No _____Initials

<u>Time Limitations and Rights to Revoke Authorization</u>

I understand that I have the right to revoke this consent at any time by giving written notice to New Beginnings, except to the extent that New Beginnings has already taken action in reliance on it. I understand that requested copies may be subject to a reasonable fee. I understand that I may not withdraw authorization for a disclosure that is necessary for the purpose of making payment to the organization for services provided.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. _____Initials

If applicable, date of revocation:_____
(Revocation must be submitted in writing.)

_____

Signature of Client or Parent/Guardian/Custodian if client under 18 years of age Date

Larry Crawford

_____

NEW BEGINNINGS Representative Date

-THIS PORTION INTENTIONALLY LEFT BLANK-