The Samaritan Center

RELEASE OF INFORMATION FORM

I, _____, authorize _____
Name of Client (print or type) — Name and Title

_____ _____
Street Address — Organization

_____ _____
City State Zip Code — Street Address

Birthdate:_____/_____/_____ Age:_____ _____
Month Day Year — City State Zip Code

and the Samaritan Center to release ☐ **Verbally** and/or ☐ **In Writing** the following information from the client's record to each other:

☐ **Check this box to allow sharing of any and all information.**

Or check individual boxes to allow the sharing of specific information:

From the Samaritan Center:		**From the above-named person/organization:**	
☐ Alcohol/Drug Use Information	☐ Medication	☐ Alcohol/Drug Use Information	☐ Medication
☐ Attendance	☐ Progress Record	☐ Attendance	☐ Progress Record
☐ Diagnosis	☐ Psychological Assessment	☐ Diagnosis	☐ Psychological Assessment
☐ Discharge Summary	☐ Social History	☐ Discharge Summary	☐ Social History
☐ HIV/AIDS Information	☐ Treatment Plan	☐ HIV/AIDS Information	☐ Treatment Plan
☐ Initial Assessment	☐ Other_____	☐ Initial Assessment	☐ Other_____

(If the client chooses to release substance abuse records, the client must sign below, **including minors**)

PURPOSE OF DISCLOSURE(S):

☐ Comply with Order of the Court
☐ Response to Referral Source
☐ To Assist with Payment
☐ Treatment of Client
☐ Other_____

This authorization is subject to written revocation at any time. When a client/legal guardian revokes consent, the Samaritan Center is not liable for items sent in the interim between authorization and revocation. Unless another date is specified, this voluntary release expires sixty (60) days after termination of treatment. Other expiration date authorized by the patient/legal guardian:_____/_____/_____

SIGNATURES (please sign below to release information):

Client:_____ _____
Date

Guardian:_____ _____
Legal Guardian if client is a minor — **Date**

Witness (optional):_____ _____
Date

SEND INFORMATION TO: **THE SAMARITAN CENTER,**
221 East Crawford Street
Elkhart, IN 46514

Attn:_____
Phone: 574-262-3597
Fax: 574-262-3599

Notice to Recipient of Information sent by the Samaritan Center: This information has been disclosed to you from records protected by the Federal confidentiality rules (42CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CFR Part 2. A general authorization for the release of information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Date Copies Sent:_____ By Whom:_____
(Include Title)

_____ _____ _____
CLIENT NAME – Last, First, Middle — AGE — SAMARITAN NO.