

Authorization for Disclosure of Information

NOTE: All matters and records relating to the physical or mental condition of clients are privileged and confidential and are treated as such by all clinical staff at this agency. Privileged disclosure of the confidential treatment of present or past clients will not be made without the consent of the client except pursuant to judicial order, in accordance with Public Law 92-255 and Public Law 93-282.

The _____ is authorized to release information from
(Community Support Provider or Significant Other)

_____. This authorization could include release of
(Medical Records)

Information concerning treatment of drug or alcohol abuse, drug related conditions, alcoholism, psychiatric/psychological conditions, AIDS/AIDS related conditions and/or HIV testing, financial information and income.

Verification of any records is also authorized:

Name: _____
Address: _____
Date of Birth: _____
Purpose of Disclosure: _____

Specific information to be disclosed: Financial Information Income Verification

During the period from _____ to _____. This consent to disclose
(Authorization) (End of Authorization)

information may be revoked by me at any time except to the extent that action has been taken in reliance there on.

“In signing this document, I authorize the release of sufficient information to the Mental Health Access Point (MHAP) and the Hamilton County Mental Health and Recovery Services Board that the Board can enroll me in the Multiagency Community Services Information System (MACSIS) and determine my eligibility for publicly funded services.”

This consent (unless expressly revoked earlier) expires 90 days from this date:

Client Signature: _____ Date: _____
CPST Signature: _____ Date: _____

Reason for revocation: _____
