



CLIENT NAME: _____
 CLIENT NUMBER: _____
 DATE OF BIRTH: _____
 SCREENING/ADMIT DATE: _____

Authorization to Release and/or Request Protected Health Information (PHI) From/To Family Members and/or Friends

I hereby authorize Solutions Outpatient Services to disclosure PHI to and/or from the following professional:

and

Solutions Outpatient Services

4300 MacArthur Avenue, Suite 270
 Dallas, Texas 75209
 Phone: (214) 369-1155
 Fax: (214) 369-1710
 Email: info@sosdallas.com
 Website: www.sosdallas.com

Name	Relationship	
Street Address	Apt. #	
City	State	Zip Code
Home Phone	Cell Phone	Work Number
Email	Fax Number	

Check all types of PHI to be disclosed and/or received to the above party:

INFORMATION	TO BE <u>RELEASED</u> BY <i>SOS</i>	<u>REQUESTED</u> BY <i>SOS</i>
Personal Information	_____	_____
Personal Opinions	_____	_____
Change in Condition or Status	_____	_____
Treatment Planning	_____	_____
Medical/Psychological Status	_____	_____
Discharge/Transfer Planning	_____	_____
Aftercare/Continuing Care Planning	_____	_____
Screening/Assessment Results	_____	_____
Other (specify) _____	_____	_____

Check all methods for releasing PHI: Telephone Written Email Facsimile Telehealth Communication

This information is needed to assist Solutions in determining and coordinating my treatment efforts.

I understand that:

- My health information is protected by federal regulations (Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and/or HIPAA, 45 CFR) and state privacy laws, and disclosure is allowed with my authorization except in limited circumstances described in Solutions' Privacy Notice. I understand that I have a right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws.
- I can revoke this consent at any time except to the extent that action has been taken in reliance on it. Solutions' Privacy Notice outlines the procedure for revocation. This authorization will expire in one year from the date I sign it unless I request an earlier expiration in writing.
- For disclosures other than for treatment, payment and health care operation purposes, treatment may not be conditioned on my agreement to sign an authorization (unless I am receiving care solely to create protected health information for disclosure to a third party [42CFR, 164.508(b)(4)(iii)]).
- Communications resulting from this authorization will reveal that I received services at Solutions.
- Federal confidentiality regulations (42 CFR Part 2) prohibit redisclosure of information from alcohol and drug abuse patient records. However, HIPAA requires Solutions to notify me of the potential that information disclosed pursuant to this authorization might be redisclosed by the recipient and is no longer protected by the HIPAA rules.

Client Signature _____ Date: _____

Parent/Guardian Signature (if applicable) _____ Date: _____

Intake Staff Signature _____ Date: _____

QCC _____ Date: _____

(if Intake Staff is not a QCC)