

Heart and Soul Release of Information

I, _____, whose Date of Birth is _____, authorize Heart & Soul of NM, Inc. to disclose to and/or obtain information and records from:

Name of Agency or Person_____

Phone Number: _____Fax or Email: _____

Records to be released: All records, written and verbal (if applicable to you, these include: assessment, evaluation, therapy summary, psychiatric notes/ medication information/ lab results, CCSS notes, all treatment plans, billing/ payment information, attendance, discharge or referral info, etc)

Are there any items which you wish us to exclude, please specify:

_____

I understand the following conditions of this authorization:

- If I am signing a release for an agency, the staff at that organization are automatically included. If you are signing a release for a legal matter, this release will automatically cover a courtroom audience and related agency staff if provider is subpoenaed to testify.
- REVOCATION AND EXPIRATION: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Heart & Soul of NM, Inc. at PO Box 292, Tome, NM 87060 or by email at office@heartsoulnm.com. I further understand that a revocation of the authorization is only effective on the date of the revocation and forward.
- There is no automatic expiration, however, a client can revoke this authorization anytime in writing.
- Refusal to release any information to anyone else will not affect my ability to get treatment with exception to the following circumstances: a release is needed for billing reasons or if medications are being prescribed to a minor (below the age of 18) and the provider has requested parental involvement
- I further understand that Heart & Soul of NM, Inc. will not condition my treatment on whether I give authorization for the requested disclosure. However, the referral source may have consequences for refusing to share information.
- I understand this information may be shared verbally, written, and electronically.
- RE-DISCLOSURE: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.
- Power Of Attorney: Please complete a Release of Information for Power of Attorney and submit any related court documents to our office.

PURPOSE

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. I will be given a copy of this authorization for my records upon my request.

Authorized Printed Name:_____

Signature:_____

Date:_____