

The Institute for Family Enrichment
Authorization to Release and/or Obtain Confidential Information

I hereby authorize the Institute for Family Enrichment to **(check as applicable):**

obtain from and/or release to _____
(Sources or recipients of confidential information)
 the following information regarding _____ **(please initial each item checked)**
(Name of client)
 pertaining to the time period of ____/____/____ to ____/____/____.
Date Date

- | | |
|--|---|
| <input type="checkbox"/> Intake/Initial Assessment | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Progress Reports |
| <input type="checkbox"/> Mental Health Evaluations | <input type="checkbox"/> Treatment Recommendations |
| <input type="checkbox"/> Bio-Psycho-Social Assessments | <input type="checkbox"/> School Reports |
| <input type="checkbox"/> Medical History | <input type="checkbox"/> Discharge/Transfer Summary |
| <input type="checkbox"/> Legal History | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Presence in Treatment | _____ |
| <input type="checkbox"/> Service/Treatment Plan | _____ |

I understand that:

- The purpose of this disclosure is to coordinate and facilitate evaluations, treatment, and treatment planning regarding the above-named person.
- The Institute for Family Enrichment may not condition my treatment on whether I sign this consent form, but that in certain limited circumstances, I may be denied treatment if I do not sign this consent form.
- The records of the above-named person are protected under Federal and State regulations governing confidentiality and may not be disclosed without my written consent.
- All alcohol and/or drug treatment records (if applicable) pertaining to the above-named person are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R., Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R., Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided by the regulations.
- I may revoke this consent at any time in writing except to the extent of actions already initiated relying upon this consent. Unless revoked, this consent expires on ____/____/____ or one year from the date of signature below, whichever is sooner. Date

Name of Client (print)	Signature of Client	____/____/____ <small>Date</small>
Name of Parent/Guardian when required (print)	Signature of Parent/Guardian when required	____/____/____ <small>Date</small>
Name of TIFFE Staff (print)	Signature of TIFFE Staff	____/____/____ <small>Date</small>

Recipient of Information: This information has been disclosed to you with the consent of the above client/ legal representative. This information has been disclosed to you from records protected by Federal and State Laws such as HIPAA, 45 C.F.R., Parts 160 & 164, as well as 42 C.F.R., Part 2 for any information concerning alcohol and drug treatment (if applicable). These Federal rules prohibit further disclosure of this information unless such disclosure is expressly authorized by the written consent of the person to whom it pertains or as otherwise permitted by HIPAA, 45 C.F.R., Parts 160 & 164 and 42 C.F.R., Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the disclosed information to criminally investigate or prosecute any alcohol or drug abuse client.