Recovery Ways Idaho
Healing is Possible

Consent for Release of Confidential Information

Client Name: _____ Date of Birth: _____

Regarding my protected health information, I hereby authorize Recovery Ways Idaho and/or their staff and/or their assignees to:

☐ Release To ☐ Obtain From ☐ Exchange Information with the following persons/agencies:

_____

Agency Name Phone Number Fax Number

For the purposes of: ☐ Continuity and Coordination of Care ☐ Other: _____

Format in which information is to be release: ☐ Verbal ☐ Written ☐ Other: _____

Type of record(s): ☐ Medical ☐ Psychiatric ☐ Plans, Evaluations, Assessments

☐ Drug/Alcohol Treatment ☐ Other: _____

Recovery Ways Idaho may not use or disclose my records without this consent unless authorized by law. I understand I may revoke this consent through a written, signed, and dated request at any time except to the extent that action has been taken in reliance on it.

This consent expires one (1) year from the date executed or on _____

Signature of Client/Parent/Guardian: _____ Date: _____

Re-Disclosure of Confidential Information Prohibited. This information disclosed to you is protected by State and Federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by law.

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