DCCCA, Inc.

Authorization for Requesting and Disclosing Protected Health Information

Name: Date of Birth: DCCCA#:

I hereby authorize _____, an employee of DCCCA, Inc. to:

☐ Disclose Information To ☐ Request Information From ☐ Exchange Information With

Name (include relationship to customer if a person is listed):

Address:

City: State: Zip:

Phone (Optional): Fax (Optional):

Check and initial type of information authorized to be requested or disclosed:

_____ ☐ Admission Intake
_____ ☐ Discharge Summary
_____ ☐ Psychological Evaluation Report
_____ ☐ Psychiatric Evaluation Report
_____ ☐ Substance Abuse Evaluation Report
_____ ☐ Presence in Program
_____ ☐ School Progress Reports/Records
_____ ☐ Other, specify:

_____ ☐ Medical History, Lab Results
_____ ☐ Diagnosis
_____ ☐ Treatment Plan
_____ ☐ Summary of Treatment
_____ ☐ Progress Notes
_____ ☐ Verbal or Written Progress Reports/Consultations
_____ ☐ HIV/AIDS Information

All of the records authorized above may be requested or disclosed unless restrictions are specified here:

I understand that this information will be used for the purpose of:

☐ Assessment ☐ Treatment ☐ Case Coordination ☐ Follow-up Care

☐ Other, specify:

This authorization shall remain effective, as of _____ (date of customer/legal guardian signature) until _____ (date). **If this item is left blank, the authorization shall remain in effect for 90 days after the signature date listed below.**

I, the undersigned, have read the above and authorized the request or disclosure of Protected Health Information (PHI) as described.

I understand that services are not conditioned upon the execution of this authorization.

I understand that DCCCA, Inc. cannot assure that the recipient will maintain confidentiality of the information authorized to be released.

I understand that I may revoke this authorization at any time by providing written notice to my treatment provider except to the extent that action has been taken in reliance on authorization.

Signature of Customer/Legal Guardian	Signature of Witness
Printed Name of Legal Guardian and Relationship	Date

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Law regulations (42 CFR, Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.