Focus
Southeast
Center of Excellence

Authorization to Exchange, Request or Release Information

I, _____, hereby request and authorize **SECOE**

Please indicate the purpose with **INITIALS**:
To Exchange with_____ To Release to_____ To Obtain from_____

Name of Person / Facility / Representative	Title / Relationship	Telephone No.	Fax No.

Address	City	State	Zip

I authorize the release/exchange of the following medical records and information (place "**x**" to all that apply).

__X__ All medical records	__X__ Treatment plans	__X__ Medication(s)
__X__ Diagnosis	__X__ Attendance or dates seen	__X__ Other – Explain: _____
__X__ Medical history	__X__ Psychosocial history	_____
__X__ Progress notes	__X__ Summary of psychological testing	_____
__X__ Evaluations	__X__ Verbal	_____

This information is required for (place "**x**" to all that apply).

_____ Social Sec / Disability	_____ Insurance	_____ Other – Explain: _____
__X__ Continuation of Care	_____ Legal Purposes	_____
__X__ Coordination of services	__X__ Treatment and evaluation	_____

Patient Name	Date of Birth	Social Security No.	Telephone No.
	/ /	- -	

Address	City	State	Zip

_____ I understand that my records may contain information regarding my mental health, substance use or **(initials)** dependency, sexuality, suicidality and may contain confidential HIV (AIDS) related information.

- My treatment, payment of eligibility for benefits may not be conditioned on signing this authorization.
- I may refuse to sign this authorization and that it is strictly voluntary.
- I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.
- The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by Focus Psychiatric Services.
- I may see and obtain a copy of the information described on this form, for a reasonable fee, if I request it.
- Fees/charges will comply with all laws and regulations applicable to release information.
- EXPIRATION: This authorization shall expire twelve (12) months from the date signed below, unless specified _____ and covers this treatment period only.
- Use of copies: A copy of this authorization may be utilized with the same effectiveness as the original.
- I have read the above and authorize the disclosure of the protected health information as stated.

☐ Verified that DCS has rights for educational care.

Print Name	Signature of Patient, Legal Guardian or Representative

Title & /or Relationship: _____ **Date:** _____

Signature of witness: _____ **Date:** _____

(updated: 5/13/10)

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