**Client Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release of Information – Authorization for Disclosure**

**Requesting Agency: Integrity Mental Health**

□ 1000 N Curtis Road, Suite 202 / Boise, ID 83706 /

 Ph: (208) 283-7314 / Fax: (208) 550-3204

□ 160 E Valley River Drive, Suite 4/ Rexburg, ID 83440 /

 Ph: (208) 615-8159 / Fax: (208) 615-8160

□ 1105 Ironwood Drive, Suite B / Coeur D’Alene, ID 83814 /

 Ph: (208) 758-7904 / Fax: (208 758-7905

*I authorize the following person or business to disclose confidential information about me*:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose of Disclosure: Coordination of Care**

**Information to be released: All written and verbal communication**

**This authorization is good for one (1) year. I understand I have the right to revoke this authorization, in writing, at any time, but revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization**

I understand my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. Federal rules prohibit further disclosure of this information unless expressly permitted by written consent of the person to whom it pertains or otherwise permitted by 42CFR Part 2. I release the person/agency disclosing this information from any liability arising from the release of information to the agency or person designated above.

Client or guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Top of Form