



CONTACT

Authorization Form for Disclosure of Information

Client Name: _____ Client Date of Birth: _____ Client ID #: _____

1) Are you the Client? Yes No

If "No", please indicate your name and check one of the boxes below. Also, please give the Plan copies of any papers that show you have the right to make health care decisions for the Client.

Name: _____ Telephone: _____

- I am the Client's parent or guardian
- I am authorized to make health care decisions for the Client (explain) _____
- Other (explain) _____

2) Description of information to be disclosed by Contact, and the purpose of disclosure:

Information to be Disclosed

- Complete records
- Attendance only
- Summary of attendance and progress
- Portions of case records, as specified: _____

- Assessment and Recommendations
- Other (specify) _____
- This authorization includes both verbal and written communication.

Purpose of Disclosure

- To assist in making appropriate referral
- To coordinate services and assure continuity of care
- To arrange a leave of absence from work, to return to work, or employer request
- To comply with a court order or subpoena
- Other (specify) _____

3) When disclosing the information listed above, may Contact include the following information?

- Yes No Psychotherapy notes (my provider's personal counseling notes that are not in the main medical record)
- Yes No Drug and/or alcohol abuse treatment information
- Yes No Communicable disease information, including HIV/AIDS, sexually transmitted diseases, or Hepatitis B & C

4) Description of who will receive the records:

Name of person/company: _____

Address _____ City/State/Zip _____

Phone (if known): _____ Fax (if known): _____

After your information is disclosed to another person or company, it may not be protected by the federal privacy rule and could possibly be released to someone else. **You are not required to sign this authorization.** If you do not sign this authorization, it will not affect your treatment, payment, enrollment or eligibility for benefits. You also may cancel this authorization at any time by submitting a request in writing to the address at the bottom of this page, unless Contact already released the information. This authorization will automatically expire twelve (12) months from the date of your signature, unless you list an earlier date or expiration event here:

You can get more information about how Contact treats Client's health information in the Contact Notice of Privacy Practices.

If you agree Contact may disclose your health information as described above, sign below.

Patient/Legal Representative Signature: _____ Date: _____

Relationship to Patient if signed by Legal Representative: _____

Please send this Authorization Form to:
Contact Behavioral Health Services / Attn: Privacy Officer
4645 Cotton Center Blvd., Bldg. 1, Suite 200
Phoenix, AZ 85040

Call CONTACT at 1-800-309-2242 with questions or comments.

Notice to Recipient of Information: If this information includes records protected by Federal confidentiality rules (42 CFR part 2), the Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR 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 information to criminally investigate or prosecute any alcohol or drug abuse patient.