# Release of Information Authorization

| | |
|---|---|
| **Client Name:** | |
| **Client Date of Birth:** | |
| **Client Phone Number:** | |
| **Client Driver's License Number & Issuing State/Authority*:** | |

***** If client does not have a driver's license, a state/federal identification card number, military identification card number, or passport number may be entered above.

This authorization form is used to release and/or to obtain your protected health information (PHI) as required by federal and state privacy laws. Your authorization allows HopeWay Foundation (inclusive of HopeWay Wellness) to release/to obtain your PHI to/from a person or entity that you choose. You may withdrawal this authorization at any time by submitting a written request to HopeWay (contact the Health Information Management Department at 980-859-2125 or HIM@hopeway.org for assistance). Withdrawal of this authorization will not affect any action taken prior to receipt of your written request.

**SERVICES RECEIVED FROM:**

**HopeWay - 1717 Sharon Road West, Charlotte, NC 28210**

## SECTION I: REQUESTING/RELEASING PARTY INFORMATION

I request and authorize HopeWay: ☐ To release to: ☐ To obtain from:

Person / Entity Name: _____

Address, City, State, Zip: _____

Phone Number: _____ Fax Number: _____

Email: _____

## SECTION II: METHOD OF TRANSMISSION

☐ Verbal ☐ Written ☐ Electronic

## SECTION III: TYPES OF INFORMATION TO BE RELEASED (Please, be **specific** when indicating types of information to be released.)

| | | |
|---|---|---|
| ☐ Presence & Progress in Treatment | ☐ Individual & Group Therapy Notes | ☐ Registered Dietitian Notes |
| ☐ History & Physical | ☐ Biopsychosocial Assessment & History | ☐ Psychological Testing |
| ☐ Psychiatric Assessment & History | ☐ Laboratory/Pharmacogenetics/Imaging Results | ☐ Discharge Summary |
| ☐ Psychiatric & Medical Progress Notes | ☐ HIV/AIDS Test Results and Treatment Information | ☐ Billing/Financial Information |
| ☐ Substance Use Assessment & History | ☐ Aftercare Recommendations/Discharge Plan | ☐ Other:_____ |

**DATE RANGE:**_____(e.g., "All dates of service", "10/01/2020", or "01/20/2023 to 01/25/2024".)

## SECTION IV: PURPOSE FOR THE RELEASE

The above information is being requested for release for the purpose of:

| | | |
|---|---|---|
| ☐ Client Use/Client Request | ☐ Social Security/Disability Claiming | ☐ Legal Purposes |
| ☐ Financial/Payment/Insurance | ☐ Unemployment Claiming | ☐ Special Forms/Letters |
| ☐ Continuity of Care/Evaluation/Treatment | ☐ Employment/School Continuity | ☐ Other:_____ |

## SECTION V: EXPIRATION OF AUTHORIZATION

I understand that this authorization is valid and will terminate **6 months** from the date of signature OR upon the following event/condition:_____.

## SECTION VI: REFUSAL TO SIGN

I understand that I may refuse to sign this authorization. I understand that my refusal to sign will not affect my ability (1) to obtain health care services or (2) affect my ability for treatment, payment, enrollment in a health plan or eligibility for benefits.

## SECTION VII: SIGNATURE & AUTHORIZATION

Records released may contain alcohol/drug treatment information, psychiatric/psychological information, pharmacogenetics information, HIV/AIDS information, and/or related conditions. HopeWay and many other organizations and individuals such as physicians, hospitals, and health plans are required by law, inclusive of HIPAA and 42 CFR Part 2 (as applicable to alcohol/drug treatment information), to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

Client (or Legal Representative) Signature: _____

Date: _____

If signed by Legal Representative, relationship to client: _____

Printed Name of Legal Representative: _____

## SECTION VIII: WITHDRAWAL OF AUTHORIZATION

I understand that I have a right to withdraw this authorization at any time. I understand that if I withdraw this authorization, I must do so in writing and present my written withdrawal to the releasing person/agency. I understand that the withdrawal will not apply to information that has already been released in response to this authorization.

**Version Date: 04.23.2024**