Multi-Agency Consent for the Release of Confidential Information

_____   _____   _____
(Name of Consumer)   (Record #)   (DOB)

The purpose of this form is to allow me to choose how my services are coordinated. I understand that this is my decision to make and that I can change my mind. If I change my mind, I need to make a written request to cancel this consent. This request will go to the agency or program's Medical Record or Health Information Department for processing. I also understand that I can ask a staff member to assist me with this process. If I have a legal guardian, my guardian may sign or cancel this consent on my behalf.

By checking yes, I am allowing these providers to communicate and exchange information needed to coordinate and continue care, treatment and services. If I check no, I do not want the information exchanged with that provider.

Yes	No	Provider/Agency Name
☐	☐	Please provide records for all of the following facilities listed:
☐	☐	
☐	☐	
☐	☐	
☐	☐	

Yes	No	Types of Information	Yes	No	Types of Information
☐	☐	Demographic	☐	☐	Lab/X-Ray Reports
☐	☐	Assessments	☐	☐	Admit/Discharge Dates
☐	☐	Physical Exam	☐	☐	Release/Discharge Summary
☐	☐	Treatment Plan(s)	☐	☐	Housing Information
☐	☐	Medications	☐	☐	
☐	☐	Other: Please describe: Mental Health Records			

Date, Event or Condition when Consent Expires: _____. In the event no date/event/or condition is specified, this consent expires on year from the date of signing.

I understand that treatment services are NOT contingent upon or influenced by my decision to permit the information release.

I understand that the information and records disclosed pursuant to this consent may be protected under 42 CFR Part 2, governing Alcohol and Drug Abuse patient records, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 45 CFR parts 160 and 164, State Confidentiality laws and regulations, and cannot be released without my consent unless otherwise provided for by the regulations. State and Federal regulations prohibit any further disclosure of such information and records without my specific written consent unless otherwise permitted by such regulation.

The information I authorize for release may include records that may indicate the presence of a communicable or venereal disease, which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS).

_____ /_____   _____/_____
Signature of Consumer   Date   Witness (optional)   Date

_____ /_____   _____
Signature of legal guardian, if required   Date   Relationship to consumer

04/03/2019