InterCommunity
Health Care for the Whole Person

InterCommunity, Inc.
Authorization to Obtain/Release/Use Information

Please note that this is a legal document and will not be honored unless it is completed in full.

Client Name: ______________________ SSN: ______________ DOB: ______________

I AUTHORIZE: [X] **InterCommunity, Inc.** and [X] **InterCommunity Recovery Centers, Inc.** and their representatives to **OBTAIN / RELEASE** the information described below to be **USED for the purpose(s) of** (any other use is prohibited):

____

DATE, EVENT, OR CONDITION WHEN THIS AUTHORIZATION IS TO EXPIRE: (should be related to purpose(s) of authorization): ____

FROM/TO: (name and address of person and agency information is to be obtained from or released to):

____

The records and information to be obtained / released shall include: (check the appropriate boxes)

☐ Entire client record, including information/records pertaining to medical, psychiatric, other health related information, and information/records received from other health care providers, the Department of Children and Families, the Department of Corrections and other government agencies or third parties. Psychotherapy notes will not be included.

☐ Include only the following specified information/records from the client record, including information from other health care providers or agencies. Psychotherapy notes will not be included: (check the appropriate boxes)

- ☐ Comprehensive Assessment (including, but not limited to, information about personal and family history, functional assessment, treatment history, risk assessment, and medical conditions including diagnoses).
- ☐ Master Service Plan (including, but not limited to, interval history, treatment goals and progress towards them, diagnoses).
- ☐ Records from/relating to the CT Department of Children and Families, parole, probation or other agencies
- ☐ Other: (specify)______________________________

☐ Psychotherapy Notes (if checked, no other types of records above may be requested in this authorization)

The following information/records shall be included only if checked: (check the appropriate boxes)

☐ Substance Abuse information ☐ Mental Health information ☐ HIV-related information

Dates of treatment covered by this release: (check only one)

- ☐ All prior episodes of care, through discharge, from present episode of car
- ☐ Limited to the following dates/programs: ______________________________
- ☐ Ongoing Communication: I authorize ongoing information exchange, oral or written
  This exchange will expire: ______________________________ (insert date or expiration event)

I understand that refusal to grant permission will in no way affect my right to obtain present and future treatment except where disclosure of such communications and records is necessary for treatment. I understand that I may revoke this authorization at any time when I sign the "Cancellation" section of this release, unless action has been taken in reliance on this authorization, which includes circumstances where the authorization was obtained as a condition of receiving third party payment. I understand the reasonable benefits and disadvantages of my decision concerning release of the information specified above.

I understand that the information/records used or disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws; provided that if I am authorizing the release of HIV-related, mental health, or substance abuse treatment information/records, the recipient is prohibited from further disclosing such information/records without my specific written consent unless otherwise permitted under federal or state law.

______________________________ ______________
Client Signature or Personal Representative Date
Description of Personal Representative authority (must supply proof): ______________________________

Cancellation of Authorization:

______________________ ______________
Client Signature *Date*

Revised: 1/23/2018