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/to obtain your protected health information (PHI) as required by federal and state privacy laws. Your authorization allows HopeWay Foundation (inclusive of HopeWay Wellness and HopeWay Veterans Program) and HopeWay Psychiatry & Associates 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 Medical Records Department at 980-859-2125 or medicalrecords@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 Foundation, located at 1717 Sharon Road West, Charlotte, NC 28210

☐ HopeWay Psychiatry & Associates, located 5925 Carnegie Boulevard, Suite 525, Charlotte, NC 28209

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.)

☐ Verbal Communication/Consultation	☐ Presence & Progress in Treatment	☐ Therapist's Clinical Notes
☐ History & Physical	☐ Biopsychosocial Assessment & History	☐ Psychological Testing
☐ Psychiatric Assessment & History	☐ Laboratory/Pharmacogenetics/Imaging Results	☐ Discharge Summary
☐ Provider's 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 "01/20/2019 to 02/25/2019".)

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	☐ Other:_____
☐ 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: 02.22.2022