BLOOM CONSULTING
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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Name: _____ DOB: _____ SSN: XXX-XX-_____

I give permission for _____ to release my confidential information to:

Recipient: _____ **Tel**: _____
_____ **Fax:** _____
_____ **Email:** _____

Informtion to be released: Check all that apply if less than all Protected Confidential Information is subject to this realease:

____All Protected Confidential Information
____Psychiatric Evaluation
____Determination of Mental Retardation
____Drug and/or Alcohol Assessment
____Crisis Assessment
____MCOT Assessment
____Narrative Assessmnts
____Completion of Disability Questionaire
____Educational Records
____Diagnosis Review
____Medical Chart
____Medication Listing
____Psychotherapy Notes
____Prescriber's Progress Notes
____Nurse's Progress Notes
____Caseworker's Progress Notes
____Consultation Reports
____Diagnostic Reports
____Face Sheet
____UA Results/ Lab Results
____Medical History
____Name of Service Provider
____Dates of Services
____Appointment Dates/Times
____Discharge Summary
____Other: _____

I understand that this authorization extends to all information contained in my records about mental illness, developmental disabilities, chemical or alcohol dependency, communicable diseases such as AIDS and HIV, genetic information, and any other types of protected health information. **This release also allows my provider listed above to speak with the Recipient about these records and my treatment.**

Information to be released should cover the time period from beginning of treatment/care to current and continuing.
If no time period is given, the information released will cover the most recent six(6) months.

THE PURPOSE OF THIS RELEASE IS FOR THE FOLLOWING:

___ Legal ___ Disability Benefits ___ At my request ___ School ___ Other: _____

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand that I can see the protected health information that will be disclosed. If this information is for myself, I can request that it be given to me electronically. I understand that my protected health information may be released electronically.

This authorization can be cancelled at any time, in writing, to the service provider listed above, but the cancellation will not affect any disclosures already made prior to receipt of cancellation notice. The service provider listed above cannot control how the protected health information will be used by the agency/person who receives it under this authorization.

Unless cancelled or otherwise specified, this authorization will expire one year from date of signature.
Other specified date: _____

Client Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

DISCLOSURE STATEMENT: This information may be disclosed to you from records protected by Federal confidentiality rule 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.