River Valley Counseling Center

RELEASE OF INFORMATION FOR HUB-THERAPEUTIC MENTORING

Name of Person Served: _____ Date of Birth: _____

Client ID Number: _____ Phone Number: _____

Release from River Valley Counseling Center (RVCC): I authorize RVCC/TM to release my child's protected health information to:

Name: _____

Address: _____

What to Release: Dates of Service: From: _____ To: _____.

Please include the following information: ☐Entire Record, *OR* the following (check all that apply)

- ☐Psychosocial Assessment
- ☐Diagnosis
- ☐Discharge/Transfer Summary
- ☐Treatment Plan, Summary or Update
- ☐Presence/Participation/Progress in Treatment
- ☐Other: _____
- ☐Nursing/Medical Information
- ☐Psychiatric Evaluation
- ☐Medication Management Information
- ☐Letter/Form regarding disability status or fitness for an activity
- ☐School/Academic

Purpose of Request: ☒Facilitate Care ☐Legal ☐Request of Person Served ☐Other: _____

Release to (RVCC): I authorize _____ to release my child's protected health information to:

River Valley Counseling Center/TM, P.O. Box 791, Holyoke, MA 01041

What to Release: Dates of Service: From: _____ To: _____.

Please include the following information: ☐Entire Record, *OR* the following (check all that apply)

- ☐Admission and Discharge note for hospitalization of (dates) _____
- ☐Discharge/Transfer Summary
- ☐Treatment Plan, Summary or Update
- ☐Presence/Participation/Progress in Treatment
- ☐Medication Management Information
- ☐Other: _____
- ☐Nursing/Medical Information
- ☐Psychiatric Evaluation ☐Psychosocial Assessment
- ☐Laboratory & Diagnostic Studies
- ☐School/Academic

Purpose of Request: ☒Facilitate Care ☐Legal ☐Request of Person Served ☐Other: _____

Release of Privileged Information: I understand that my record may include statutorily protected information as described below. I approve the release of this information, unless the (☐ *do not release*) checkbox is checked (☒):

Alcohol and/or drug abuse diagnosis or treatment (☐ *do not release*)

Behavioral/Mental Health diagnosis or treatment (☐ *do not release*)

Domestic Violence Counseling (☐ *do not release*)

Sexually Transmitted Diseases (☐ *do not release*)

Sexual Assault Counseling (☐ *do not release*)

Psychotherapy Notes (☐ *do not release*)

Attention Genoa Pharmacy Clients: Please note that this release constitutes permission to share your demographic information with the pharmacy staff.

*Release of HIV/AIDS Information: I hereby authorize the release of my health information pertaining to HIV and/or AIDS related testing, diagnosis and/or treatment.

Signature: _____ Date: _____

Individual Rights: I understand the following:

- I have the right to revoke this authorization at any time.
- If I revoke this authorization, I must do so in writing to the attention of the Medical Records Dept, RVCC, 303 Beech St., Holyoke, MA 01040, or must contact the party whom I had authorized to release the information, if other than RVCC.
- My right to revoke does not apply to information already released on the basis of this authorization.
- The privacy of my health records is protected under "HIPAA." 45 CFR. pt3 160 & 164 and the privacy of any alcohol and/or drug treatment records are also protected under the Federal Confidentiality & Drug Abuse Records regulations. 42 CFR. pt 2.
- I understand that RVCC cannot guarantee that the Recipient will not re-disclose my health information to anyone else.
- There may be a charge for providing copies of medical records.

Expiration Date: This authorization will expire in one year unless revoked or otherwise specified to be the following date, even or condition:

_____Conclusion of this Treatment Episode (initials)

_____Other: _____ (initials)

Signature: _____ Date: _____

If not signed by person served, specify relationship: ☐ Parent ☐Next of Kin ☐Legal Guardian/Designee