TIDES OF LIFE
PO Box 571
Shelbyville, IN 46176
317-398-8361

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name ____
Address______________________City___________State_______Zip________
Date of Birth__________________ Social Security Number ________________

1. I authorize TIDES OF LIFE to: (check one)

___Obtain From: ____Release From: ____Release to and Obtain From:

Name: ____
Address______________________City___________State_______Zip________
Phone__________________________ FAX _________________________

2. The purpose of this disclosure:

____Continuity of Care ___Medical Planning ___Coordinate EAP benefits

____Verify Attendance ___Obtain Insurance Authorization ____Attorney

____Other (specify) ____

3. Description of the Information to be released (Choose one):

____ All information contained within the Medical Records including information regarding drug and alcohol, mental health and AIDS related records.
____Other Specified Records: ____

4. I understand that this authorization may be revoked at any time and will expire upon the occurrence of the following condition or date. (Choose one):

____60 days past the termination of services at Tides of Life
____ Date: _______(A date must be entered)

5. _________________________________ _____________________________
Signature of Patient/Legal Representative Witness Signature

____
Relationship Date

This information has been disclosed to you from records protected by the Federal Confidentiality Rules (42 CFR Part 2). These Federal rules prohibit you from making any further disclosure of this information, unless further disclosure is expressly permitted by the patient or as otherwise permitted by the 42 CFR Oar 2. A general authorization for the release of is information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any drug or alcohol patient.