Heart to Hand, Inc.
"A heart that cares with hands to help"

# Authorization of Release and Exchange of Information

**Name: _____ DOB: _____**

**Address: _____ City, State and Zip: _____**

□ I authorize Heart to Hand, Inc. to obtain and/or release information from:

Name of Provider or Facility: _____

Address: _____ City, State, and Zip: _____

Phone: _____ Fax: _____

Type of Records Authorized:

- □ Psychiatric/Psychological Evaluation and/or Treatment
- □ Drug/Alcohol Evaluation and/or Treatment
- □ HIV/AIDS information (labs, medications, progress notes)

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/programs identified as often as necessary to fulfill the purpose identified in the document.

My Authorization will expire:

- □ When I am no longer receiving services from Heart to Hand, Inc.
- □ One Year from this date
- □ Other _____

***I understand that:***

- ***I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain services.***
- ***I may cancel this authorization at any time by submitting a writing request to Heart to Hand, Inc.***
- ***If the authorized information is protected by Federal Confidentiality Rules 41CFR, part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulation.***

**Signature of Patient or Patient's Legal Rep: _____Date: _____**

**Print Name (if not patient): _____**

I acknowledge that the patient or patient's legal representative has been provided a copy of this authorization.

Agency Rep. Signature (Witnessed & Explained by): _____ Date: _____

Print Name: _____