

CHILDREN'S RESOURCE GROUP / CRG ASSOCIATES
Authorization for Disclosure of
Drug and Alcohol PHI

I, _____, the undersigned, hereby authorize Children's Resource Group / CRG Associates to use or disclose protected health information of the Patient identified below in the manner described in this authorization:

Patient's Name: _____ **Patient's Date of Birth:** _____

Children's Resource Group / CRG Associates has permission to:

****Mark with an "X" and complete lines below.** Release PHI ____ Obtain PHI ____ Exchange PHI ____

If to a person:

_____	_____
Last Name, First Name	Association or relationship to Patient
_____	_____
Address (Street, City, State, Zip)	Telephone and/or Fax

If to an entity:

_____	_____
Legal Name	Address (Street, City, State, Zip)
_____	_____
Contact Person(s)	Telephone and/or Fax

The PHI to be disclosed is as follows:

****Mark with an "X" on all applicable sections before signing.**

____ Progress Notes/Appointment Records ____ Treatment Summary
____ Other (Please specify): _____

State the specific purpose for the disclosure below:

I, the undersigned, have read or been informed of the following:

- (1) I understand that my signature on this Authorization is voluntary and my refusal to sign will not affect my ability to receive treatment from the Practice.
- (2) I understand that I have a right to revoke this Authorization at any time but any such revocation will not apply (1) to PHI that has already been released in reliance on this Authorization, or (2) to PHI created by the Practice expressly for disclosure to the above-listed Person/Entity.
- (3) I understand that this authorization will expire in one hundred eighty (180) days from the date the authorization is executed, unless revoked by me prior to that date.
- (4) I understand that the PHI disclosed is not to be re-disclosed by the Person/Entity receiving it, and the PHI will be clearly stamped "Do Not Re-Disclose" and protected accordingly under 42 CFR part 2.
- (5) I understand that if I have any questions regarding the use or disclosure of my PHI related to drug and alcohol treatment, I can contact Children's Resource Group at any time.

Patient Name

Date

Patient Signature

*A minor must always sign to release information even to his or her parent or guardian.

*If Legal Representative is to sign for patient, proof of such authority to act for the patient must be included.