SAGE Counseling
Social Accountability Guidance & Education
1830 S. Alma School Rd.
Suite 101 Mesa, AZ 85210
480-649-3352

AUTHORIZATION FOR RELEASE OF INFORMATION

(PLEASE PRINT CLEARLY)

Name: _____ DOB: _____ Date: _____

Address: _____ SSN: _____

Phone: Home _____ Cell _____ Case #: _____

I, _____, hereby authorize ***SAGE*** to share and exchange information from my case record with:

(SPECIFY PROBATION/PAROLE OFFICER'S NAME AND ADDRESS)

Person/Agency & Address _____

Person/Agency & Address _____

(INITIAL ONE OR MORE)
To release, for the continuity of care and to maintain my medical record, protected health information related to any of the following, **initial all that apply**:

___ Assessments/Evaluations
___ Diagnosis/Prognosis
___ Triage/Discharge Summary
___ Treatment/Service Plans
___ Progress Notes
___ Psychiatric/Mental Health Information
___ Progress Update Reports
___ Medications
___ Test Results/Labs
___ Other (Specify) _____
___ Child Abuse/Neglect
___ Probation/Parole Requirements
___ Oral Communication
___ Alcohol and/or Drug Use

I understand that my protected health information may be used and disclosed to carry out treatment, for payment of services, or for health care operations to improve the quality of care by ***SAGE.*** I acknowledge receipt of the ***SAGE*** Notice of Privacy Practices and I understand that I have the right to review the Notice before signing this consent. I understand that any changes in the Notice will be posted at all SAGE sites and are available to me upon request. I understand that this authorization is in effect for one calendar year from the date on this form.

The confidentiality of alcohol and/or drug abuse client records maintained by ***SAGE*** is protected by federal law and regulations. Except under special circumstances, ***SAGE*** may not orally disclose to a person outside the program that a client attends the program. SAGE also may not disclose any information identifying the client's history of alcohol and/or drug abuse unless: by written authorization by the client; by written court order; or the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation process. (Federal Law references 42 U.S.C. 290 dd-3 – Federal Regulation reference CFR, Part 2)

I understand that I have the right to request in writing that ***SAGE*** restrict how my protected health information is used to carry out treatment, payment, or health care operations. I understand that ***SAGE*** is not required to comply with my request.

I understand that I have the right to revoke in writing this authorization to release my protected health information.

_____	_____	_____
Client Name	Client Signature	Date
Legal Representative Name	Legal Representative Signature	Date
Witness Name	Witness Signature	Date