Alabama Department of Mental Health
Autism Services

_____
Name of Individual/Patient/Applicant

_____
Date of Birth AND/OR Social Security Number

Authorization for Release of Information-Standard Request

I hereby authorize the disclosure of records/information

From: _____
(Name of healthcare provider holding information-releasing agency)

_____
(Address) (Phone/Fax)

To: _____
(Name of Person or Agency to whom information should be given-requesting agency)

_____
(Address) (Phone/Fax)

The purpose of the disclosure authorized in this is to: _____

_____
(Purpose of disclosure, as specific as possible)

I understand that my alcohol/drug treatment records are protected under the Federal regulation governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42, C.F.R. Part 2, and Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 C.F.R, Parts 160 and 164 and cannot be disclosed without written consent unless otherwise provided for regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____
(Authorization is valid for one year from the date listed below)

PROHIBITION OF REDISCLOSURE OF CONFIDENTIAL INFORMATION

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F. R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C. F. R. Part 2. A general authorization for the release of medical or other information is **not** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____
Signature of Individual/client or person authorized to sign for client Date

_____
Reviewing Autism Services Representative Date