RIMROCK TRAILS

Authorization for Release of Information

To our individuals: We can help you better if we are able to work with other agencies that know you and your family. By signing this form, you are giving permission for these organizations/individuals to share information about you.

Individual's Name: _____ **DOB:**_____

I authorize the following individuals or agency:

to provide information to and obtain information from Rimrock Trails Treatment Services

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Including records of: **Please Check and Initial**

☐ Yes _____	☐ No	Family History	☐ Yes _____	☐ No	Mental Health Services
☐ Yes _____	☐ No	Employment/Unemployment	☐ Yes _____	☐ No	Medical/Psychiatric Treatment
☐ Yes _____	☐ No	Educational Reports	☐ Yes _____	☐ No	Alcohol/Drug Treatment
☐ Yes _____	☐ No	Rimrock Trails Admission Status	☐ Yes _____	☐ No	Demographic Information
☐ Yes _____	Other as listed: _____				

Alcohol/Drug, Mental Health and Medical Records include all aspects of diagnosis, treatment and prognosis. Educational records include both behavioral and progress reports.

I agree that agencies and/or individuals listed on this document may share and exchange information about me as indicated above. The information received will be used to evaluate my situation and to plan for and coordinate services for me and my family, or for other purposes as specified: _____

I understand this permission is good until six months after the date of discharge from the current treatment period with Rimrock Trails Treatment Services or until: _____

I can cancel at any time, but I understand that the cancellation will not affect any information that was released prior to the cancellation. I understand that information about my case is confidential and protected by state and federal law. I approve the release of this information. I understand what this agreement means, and I am signing on my own and have not been pressured to do so.

Individual Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date: _____

To those receiving information under this authorization: **THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS PROTECTED BY FEDERAL LAW (42 CFR PART 2). FEDERAL RULES PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS DISCLOSURE IS EXPRESSLY PERMITTED BY THE WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE ALLOWED BY 42 CFR PART 2. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE.**