Peacetree
FAMILY INSTITUTE

AUTHORIZATION FOR EXCHANGE AND RELEASE OF INFORMATION

I understand that:

- I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment.
- I may cancel this authorization at any time by submitting a *written* request to Peacetree Family Institute Ltd. except where a disclosure has already been made in reliance on my prior authorization, so if I revoke this authorization after a disclosure is made, it will not have any effect on actions taken by Peacetree Family Institute Ltd. in reliance on it before I revoked it.
- The information released may be subject to release by the person(s)/agency receiving it and no longer protected by the federal privacy regulations. If the person of facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information requires additional information.
- If the medical record information is not sent to another care provider, there may be a charge of the requested records.
- A photocopy (or fax) of this authorization will be treated in the same manner as the original.
- This release expires in one year unless otherwise noted below.

Patient Information:

Full name: _____ Date of Birth: _____

Address: _____ Address line 2: _____

City: _____ State: _____ Zip code: _____

I authorize Peacetree Family Institute to receive information from and release information to:

Agency/Individual Contact: _____

Address: _____Address line 2: _____

City: _____ State: _____ Zip code: _____

Phone: _____ Fax: _____ Email: _____

My authorization will expire:

☐ 60 days after I am no longer receiving services from Peacetree Family Institute, to allow for discharge documents to be generated and released.

☐ One year from this date.

☐ Other: _____

Information to be Exchange and Released:

The following information will be released verbally and/or in writing (Check boxes that apply):

☐ **All Records and Ongoing Communication OR**

☐ Diagnostic Report
☐ Treatment Plan
☐ Progress Report
☐ School Records
☐ Testing Results
☐ Medical History Case Records
☐ Family History
☐ Referral
☐ Psychological/ Psychiatric Evaluation
☐ Ongoing consultation
☐ Discharge Summary
☐ Other: _____

This release is required for the purpose of (Check boxes that apply):

☐ Coordination of services
☐ Planning appropriate treatment
☐ Social service involvement
☐ Continue/ follow-up care
☐ Case review
☐ Reunification Services
☐ Legal/Court involvement
☐ Other: _____

Patient Signature: _____Date: _____

Or

Printed Name of Guardian: _____Date: _____

Guardian Signature: _____Date: _____

The information above is required for HIPPA compliance. Please ensure all information is accurate and legible. If insufficient or unclear information is provided, you will be required to fill out a new document. Thank you for your patience and participation.