Rainbow Treatment Center
P.O. Box 1790
Whiteriver Az, 85941
(928) 338-4858
Fax: (928) 338-4100

Release of Information Consent

Client's Name:			
Address:	**City:**	**State:**	**Zip:**
Phone:	**DOB:**		

I, ___________________________________, authorize Rainbow Treatment Center to:

☐ Send ☐ Receive the following: ☐ To: ☐ From:

Name of Organization:		
Address:	**City:**	
State:	**Zip:**	**Phone Number:**

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR PSYCHOTHERAPY NOTES.

Academic Testing Results
☐ Behavior Programs
☐ Progress Reports
☐ Intelligence Testing results
☐ Medical Reports
☐ Personality Profiles
☐ Psychological Reports
☐ Court Orders/Records
☐ Psychological Testing Results
☐ Service Plans
☐ Summary Reports
☐ Vocational Testing Results
☐ Entire Record, except Progress notes
☐ ***Psychotherapy Notes** (see above note)
☐ Psychiatry Notes
☐ Social Service Plans
☐ Other (Specify):_________________

The above information will be used for the following purposes:

☐ Planning appropriate treatment or program
☐ Continuing appropriate treatment or program
☐ Determining eligibility for benefits or program
☐ Case Review
☐ Updating Files

Other (Specify):____________________________________

I understand that this information may be protected by Title 42 (Code or Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and that I may revoke this consent at any time by providing written notice and that after one year this consent automatically expires. I have been informed of what information will be disclosed, its purpose, and who will receive the information. I understand that I have a right to refuse to sign this authorization.

Client's Signature: ______________________________ Date: ______________

Witness Signature: ______________________________ Date: ______________

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of the court records (guardianship papers) indicating authorization to receive or release this protected health information.

Relationship to Client:

☐ Legal Guardian

☐ Other (describe):____

Legal Guardian/
Representative
Signature: ____________________________________ Date: ______________

Witness Signature: ______________________________ Date: ______________