**Daybreak**  Counseling Services

 54 South State St. (302)632-8842/ (302)422-7021

 Dover, DE 19901 Fax (302)422-3360

AUTHORIZATION FOR RELEASE OF INFORMATION

**Section A:** Must be completed for all authorizations

I hereby authorize Daybreak Counseling Service and/or its staff to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list the family members or other persons; if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations).

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have an answering machine, may we leave messages regarding appointments, treatment and/or information pertinent to your healthcare and/or payment for your healthcare provided at Daybreak Counseling Service? (check one)

 OK TO CALL NOT OK TO CALL

If “NOT OK TO CALL”, how else may we contact you regarding this information?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section B:** Must be completed *ONLY* if you are requesting restrictions on use and disclosure of your health information.

 I would like to request restrictions regarding the use of my health care information?

 YES (complete Restriction Request Form) NO

The patient or the patient’s representative must read and initial the following statements:

1. I understand my health care and the payment for my health care will not be affected if I do not sign this form. Initials: \_\_\_\_\_\_\_\_\_\_\_\_
2. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. Initials: \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section C:** Must be completed for all authorizations

The patient or the patient’s representative must read and initial the following statements.

1. I understand that this authorization will expire on \_\_/\_\_/\_\_(DD/MM/YY) Initials: \_\_\_\_\_\_\_\_
2. I understand that I may revoke this authorization at any time by notifying Daybreak Counseling Service in writing, but if I do it won’t have any effect on any actions taken before receipt of my revocation. Initials: \_\_\_\_\_\_\_\_

Daybreak Counseling Service will not condition my treatment on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or patient’s representative \*\* Date

(Form MUST be completed before signing)

Printed name of patient’s representative (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to the patient (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*YOU MAY REFUSE TO SIGN THIS AUTHORIZATION\*\*