**Release of Information**

I authorize

whose offices are at W Schaffer & Associates to disclose and/or obtain from the following physician, psychiatrist, hospital, other treatment provider or organization, relative, friend or any other person I choose to name below:

Name:

Address:

Phone:

Fax:

**By signing below:**I acknowledge that the following information may be released, discussed, or disclosed. If you agree to the release of all protected health information (PHI), then just check the first option. If you want to limit what is released, then choose which option you agree to and check that option.

Complete medical/mental health record  
Discharge summary  
Group therapy assessment/progress notes  
HIV/AIDS related information, diagnosis, and test results  
Medical records  
Medication Management Information  
Mental Health Diagnosis  
Progress notes  
Substance Abuse Information (including assessment & treatment records)  
Treatment plan

I understand that my records are protected under federal regulations governing Confidentiality of Protected Health Information (PHI) under HIPAA and Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part-2 and cannot be disclosed without my consent unless otherwise provided for in the regulations. I also understand that I may revoke this authorization and must do so in writing and present this written revocation to W Schaffer & Associates. Unless otherwise revoked, this consent expires in 12 months from this date. I understand that once information is disclosed per my authorization, the information may be redisclosed by the recipient in accordance with applicable laws and regulations and it may not be protected by federal or state privacy regulations.

Ongoing verbal communication:

YES NO

Signature: Date: