Client Authorization for Release of Protected Health Information

Client Name (First/Middle/Last): ________________________________________________

Address: ______________________ City: ______________ State: ______ Zip:______________

Social Security Number*: __________________ DOB: _____________Phone:_______________

1.I authorize the following health care provider or facility to **RECEIVE & DISCLOSE** my patient information.
Julander Inner Strength & Potential, 189 S State Street Ste 245, Clearfield Ut 84015, phone: 385.298.7185
2. I authorize the following person or organization to **RECEIVE & DISCLOSE** my patient information:
(Court, Judge, Probation/Parole Officer, Medical Provider, Attorney, Family, Friend, Clergy, Employer)

▢ Name/Organization/Phone: ______________________________________________________
▢ Name/Organization/Phone: ______________________________________________________
▢ Name/Organization/Phone: ______________________________________________________
▢ Name/Organization/Phone: ______________________________________________________

3. Please disclose the following information: Assessment, Treatment, Compliance, Completion and Referral
4. Disclosure may occur to: Obtain Information, Provide updates, Facilitate Court Process & provide referral
5. I understand that sanctions may be applied if I revoke my consent
6. If applicable, I understand that based on the information I designated above, the disclosure Julander Inner Strength & Potential makes pursuant to this authorization may include information regarding my participation in a substance abuse treatment program. I understand my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPPA”), 45 CRF Parts 160 and 164.
7. I understand Julander Inner Strength & Potential will no condition treatment, payment enrollment or eligibility of benefits on whether I sign this authorization. I may inspect or copy any information used under this authorization.
8. I understand I may revoke this authorization in writing at any time by sending a written revocation of authorization to: Julander Inner Strength & Potential attn: Medical Records, 189 S State St Ste 245 Clearfield Ut 84015. I understand my revocation is not effective to the extent that action has been taken in reliance on this authorization. This authorization expires 1 year from the date below.

**I have read the above, understand it, and hereby give my consent to the above-mentioned receipt & disclosure.**

| ______________________________ | ____________ | ______________________ |
|---|---|---|
| Signature of Patient or Representative * | Date | Julander ISP Witness |
| ______________________________ | ____________ | |
| Signature of Responsible Party | Date | |

“If client is a minor, signature of the legal guardian is required. ▢Parent ▢Guardian