Thrive Counseling of Idaho, Inc.
3023 E. Copper Point Drive, Meridian, Idaho 83642
(T): (208) 914-8924; (F): (208) 955-2703

Release of Records Exchange

REQUEST FOR AND AUTHORIZATION TO RELEASE RECORDS OR HEALTH INFORMATION

By my signature below, I ____ authorize Thrive Counseling of Idaho, Inc. to ***release***; and/or, ***obtain*** personal health information to/from:

Provider Name: ____

Address: ____

Telephone: ____

Facsimile: ____

And have access to; or, release the following records: ______________________

Current Medical Information and/or Medical Records
Evaluation, Assessment, or Diagnostic Reports or Documentation
Treatment Plan(s); or, Update, Addendums to Treatment Plan(s)
Other (please specify): ____
IEP or school-related reports
Progress-Session Notations

For the following PARTICIPANT: ________________________________ (DOB: ______________)

For the purpose(s) OR need: For Treatment Purposes; as well as, maintain current, accurate documentation in participant record

AUTHORIZATION STATEMENT:

I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by Thrive Counseling of Idaho. Re-disclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, this written authorization will have an expiration date of one (1) calendar year from the authorized signature below.

THRIVE may only use or disclose your personal health information for purposes as required by law or regulations and will continue to protect your personally identifiable health information as described in the Informed Consent form(s) provided.

With my signature below, I understand what this document states and authorize release of my personal health information as stated above. I understand I will be given a signed copy of this Authorization for my records, if requested.

______________________________ ______________________
Participant Signature (if applicable) Month/Date/Year

____
Print Participant Name

______________________________ ______________________
Signature of Legally Authorized Representative (if applicable) Month/Date/Year

____
Print Legally Authorized Representative Name

______________________________ ______________________
Representative, Thrive Counseling of Idaho Month/Date/Year

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PARTICIPANT-CLIENT MEDICAL OR HEALTH-RELATED INFORMATION

THRIVE COUNSELING OF IDAHO honors a participant's right to confidentiality of medical or health-related information as provided under federal and state law. Please read the following guidelines before signing this authorization.

No Obligation to Sign. You are under no obligation to sign this form, and you may refuse to do so. Except as permitted under applicable law, THRIVE may not refuse to provide you treatment or other health care services if you refuse to sign this form.

Revocation. You have the right to revoke this authorization, in writing, at any time before it expires. However, your written revocation will not affect any disclosures of your medical information that the person(s) and/or organization(s) listed on the reverse side of this form have already made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and addressed to:

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Re-release. If the person(s) and/or organization(s) authorized by this form to receive your medical information are not health care providers or other people who are subject to federal health privacy laws, the medical information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your medical information without your prior permission.

Right to Inspect. You have the right to inspect or copy the medical information whose disclosure you are authorizing, with certain exceptions provided under state and federal law. If you would like to inspect your records, contact THRIVE COUNSELING OF IDAHO for further information.

Signatures. Generally, if you are 18 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of your medical information. If you are under the age of 18, your parent or guardian must sign this form for you. However, there are many situations in which this general rule does not apply. For more information regarding who is authorized to sign this form, contact THRIVE COUNSELING OF IDAHO representatives.