

HelpNet's Affiliate Client Release Authorization

I, _____, hereby authorize HelpNet's contracted Affiliate _____,
(Client's Name Printed) (Organizaion)
 _____, to obtain, release and exchange information in my client records to HelpNet
Assigned Therapist)

and only under the conditions listed below:

1) Specific type(s) of information to be disclosed:

	Yes	No		Yes	No
Assessment	___	___	Progress	___	___
Attendance	___	___	Diagnosis	___	___
Client Status	___	___	Insurance Information	___	___
Referral	___	___	Prognosis	___	___
Testing Results	___	___			
All pertinent clinical information related to a job jeopardy program				___	___
Other: _____					

2) The purpose and need for such disclosure:

___ Coordination of Services
 ___ Retention of Employment

- 3) I hereby consent to the release of any medical information, which may include the following: PSYCHIATRIC, ALCOHOL and/or DRUG ABUSE RECORDS, AIDS, AIDS-RELATED COMPLEX (ARC) and HIV INFECTION.
- 4) This patient consent form is in accordance with Public Act 56 1973 and in compliance with Title 42 of Federal Regulation Part II. It is also in accordance with Public Act 174.
- 5) A photocopy or fax of this signed consent form shall have the same force and effect as the client's original signature.
- 6) I understand that this authorization may be withdrawn by me at any time with written notice. Revocation of this authorization will not affect any information already released. This authorization shall expire without express revocation one year (12 months) from the date written below.
- 7) I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

 Client Date

 Parent/Guardian Date

 Witness Date

 Relationship to Client