Next Step Foundation, Inc.
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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, _____ , authorize Next Step Foundation, Inc. to ☐ DISCLOSE/ ☐ RECEIVE (check one or both) information contained in my record ☐ TO/ ☐ FROM (check one or both):

Organization/Agency (*required*): _____ Name (*required*): _____

Phone: _____ Fax: _____ City: _____ State: _____ Zip: _____

The information to be released is limited to the following (please check):

- ☐ Program Involvement/Attendance
- ☐ Assessment/Intake Information
- ☐ Diagnosis
- ☐ Psychological Test Results
- ☐ Psychiatric Evaluation
- ☐ Medical/Medication Information
- ☐ Housing Information
- ☐ Urine Screen Results
- ☐ Discharge Summary/Aftercare Plan
- ☐ Transportation Information
- ☐ Progress Reports
- ☐ Treatment Plan
- ☐ Other (please specify): _

The purpose of the requested use and disclosure of this information is:

- ☐ Continuity of Care
- ☐ To inform the criminal justice agency listed above regarding my treatment
- ☐ Evaluation or Assessment
- ☐ Other (please specify) _____

Note: Disclosure shall be limited to the information which is necessary to carry out the state purpose, as noted above

This consent will expire 60 days after my last contact with Next Step Foundation, Inc., unless otherwise specified below (please check):

- ☐ I agree that this consent will expire 60 days after my last contact with Next Step Foundation, Inc.
- ☐ This consent expires on the following date: _____

Next Step Foundation, Inc. cannot guarantee email encryption with outside servers. With consent, all staff shall take every action possible to encrypt patient identifying information via email. My consent to disclose information via email is as follows:

- ☐ I consent to patient identifying information to be emailed to the organization/person above when necessary.
- ☐ I do NOT consent to patient identifying information to be emailed to the organization/person above when necessary.

I understand I have the right to revoke my consent at any time, except to the extent that the information has already been released. If I wish to revoke my consent, I should submit my revocation in writing to my case manager. I understand authorizing the use or disclosure of the information identified above is voluntary and that I do not need to sign this form to receive services at Next Step Foundation, Inc. I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient. A photocopy of this authorization should be deemed valid as original.

I have read and fully understand the above statements as they apply to me. I consent to the release of records/information for the purpose(s) stated above.

_____

Signature of Client Date

Submit Print Save

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. Federal regulations (42 CFR, Part 2) prohibit you from making any further disclosure of this information without the specific written authorization for release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. This form cannot be used for the re-release of confidential information provided to Next Step by other individuals or agencies. Such requests should be referred to the original individual or agency.