H.O.P.E.

Honoring Opportunities for Personal Empowerment

Name of Participant: Medicaid #: DOB:

AUTHORIZATION FOR RELEASE OF INFORMATION

Participant: _____ SSN:_____

I, the undersigned, authorize H.O.P.E. to release and/or obtain verbal, electronic, or written information indicated below regarding the above named participant, with the following individuals and agencies:

Name/Agency_____

_____

_____

The information released will be used for the following purpose:

❒ Evaluation ❒ CPP/ELP Planning ❒ Screening ❒ Job Developing / Job Coaching ❒ Other

Information to be released (check all that apply):

❒ Social History ❒Physician's Orders ❒Treatment Plan

❒ Progress Reports ❒Annual Staffing Reports (Plan of Care) ❒Educational

❒ Evaluations ❒Discharge Reports ❒Other_____

❒ Diagnosis and Evaluations

❒ Past / Prospective Employers regarding job developing / obtaining – maintaining employment

❒ Psychiatric/Psychological Evaluations (complete bottom portion of form if this box is checked)

Take &/or use of Photos &/or video &/or media (including artwork) produced for public relations purposes or fundraising: Newsletters, in-house display, community presentations, brochures/printed material, marketing materials, website, press/media coverage.

☐ Yes ☐ No **Permission to use photos/media for all of the above**

☐ Yes ☐ No **Permission to release name with media**

This release is valid until _____. (expiration date – maximum is 1 year from date signed).

I understand that I may revoke this consent at any time and that the above named person/agency authorized to receive this information has the right to inspect and copy the information to be disclosed.

It has been explained to me that if I refuse to consent to this Release of Information, the following are the consequences (specify, if any):

_____

Participant's signature:_____ Date:_____

_____ _____

Legal Guardian Signature (if required) Date

_____

Relationship, if not participant

If signature is not of participant, indicate legal relationship to participant and legal basis on which consent is given for recipient.

_____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW:

I specifically authorize the release of information relating to:

❒Substance Abuse ❒HIV/AIDS-related information ❒Mental Health

Participant's (or legal guardian's) signature:_____

Date:_____ Relationship, if not participant_____

"This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose."