Adolescent Substance Abuse Program

2530 South Alma School Road

Mesa, Arizona 85210

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**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)**

I, authorize the disclosure of protected health information (PHI) for q myself or for q my minor child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_as follows:

The information is to be disclosed by:

Adolescent Substance Abuse Program, 2530 S. Alma School Road, Mesa, AZ 85210

 OR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(facility or professional)

And the information is to be provided to:

 NAME OF PERSON/ORGANIZATION/FACILITY

 ADDRESS CITY/STATE/ZIP

 PHONE NUMBER FAX NUMBER

(For ASAP records Please allow 5-7 business days for processing. Extra time may be required for retrieval from storage.)

The information is to be: qmailed or qfaxed

The purpose of this disclosure is: qcoordination of care qpersonal use qother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The information to be released is: q Documentation that the IOP Program was completed in full

 OR q Discharge summary

 OR q Other

 OR q No need to send records, 2- way phone conversation is sufficient

Your rights regarding the release of PHI: I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance of the authorization. This authorization shall remain in place for sixty (60) days unless further limitation is placed here by the patient and legal representative: . I understand the matters discussed on this authorization, that I may receive a copy of it, and I release ASAP and its employees of any liability for the disclosure of my information pursuant to this request. I understand that my signature is voluntary and that treatment, payment, or eligibility of benefits is not conditioned upon execution of the authorization. The requested records do include drug/alcohol treatment. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of this information and therefore may be no longer protected by the HIPAA Privacy Rule. I understand that if this information is disclosed to a third party, the information may no longer be protected by state and federal regulations and may be re-disclosed by the person or organization that received the information.

Patient signature: date

Parent/Legal Representative

(must sign if patient is a minor) date