Phone: ______________
Fax: ______________

DUAL RELEASE OF INFORMATION/AUTHORIZATION

I, ________________________________, hereby authorize the two-way release of information between

_____________________________________ (Agency/Provider) ____ (initials)

and **_______________________________ *(Center Name)*** ____ (initials).

This information is to be used for: coordination of care. ____ (initials)

This authorization expires on ___/___/___.

My authorization is given freely with the understanding that:

- My information may be subject to re-disclosure by the recipient and may no longer be protected by this agency or applicable privacy laws.
- I may revoke this authorization at any time, except where information has already been released in reliance on my authorization, provided that my revocation is in writing.
- The Agency may not condition my treatment on my provision of this authorization.
- This authorization is valid for a 12-month period from the date it is signed unless otherwise specified.
- A photocopy or fax of this authorization is as valid as the original.
- The Agency, its directors, officers, employees, agents and volunteers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

____ ____________

Peer/Client Signature Date

____ ____________

Staff/Witness Signature Date

*Note to agency/person in receipt of this information: This information has been disclosed to you from records whose confidentiality is protected under Federal Law. Federal regulations (42CFR Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization from the release of medical or other information is **NOT** sufficient for this purpose.*

Revised 5/1/19