SAGE Counseling
Social Accountability Guidance & Education

1830 S. Alma School Rd.
Suite 101 Mesa, AZ 85210
480-649-3352

AUTHORIZATION FOR RELEASE OF INFORMATION

(PLEASE PRINT CLEARLY)

Name: _____ DOB: _____ Date: _____

Address: _____

Phone: Home _____ Cell _____ Case #: _____

I, _____, hereby authorize ***SAGE*** to share and exchange information with:
(Client Name)

* ***The name of a specific person and relationship to client or agency name is required to be noted.***

1) (If MCAPD) Person: _____and Representatives_____
Agency & Address: Administration Maricopa County Adult Probation Department / 111 S 3RD Ave, 6TH Floor, Phoenix, AZ 85003

2) *Person/Agency & Address _____
Relationship to client:_____

Purpose of disclosure: _____Coordination with Probation/Parole/Court/Legal System _____ Coordination with DES
_____Coordination of Care _____Other:_____

To release, for the continuity of care and to maintain my medical record, protected health information related to any of the following, **initial below (initial ALL below, except progress notes, if ROI is for your referral source)**

___ Assessments/Evaluations/Diagnoses ___ Psychiatric/Mental Health Information ___ Child Abuse/Neglect
___ Oral Communication ___ Progress Update Reports ___ Progress Notes
___ Discharge Summary ___ Medical Information ___ Treatment/Service Plans
___ Alcohol and/or Drug Use ___ Probation/Parole/Court/Legal Requirements
___ Other (Specify) _____

I understand that my protected health information may be used and disclosed to carry out treatment, for payment of services, or for health care operations to improve the quality of care by ***SAGE.*** I acknowledge receipt of the ***SAGE*** Notice of Privacy Practices and I understand that I have the right to review the Notice before signing this consent. I understand that any changes in the Notice will be posted at all SAGE sites and are available to me upon request. I understand that this authorization is in effect for one calendar year from the date on this form.

The confidentiality of alcohol and/or drug abuse client records maintained by ***SAGE*** is protected by federal law and regulations. Except under special circumstances, ***SAGE*** may not orally disclose to a person outside the program that a client attends the program. SAGE also may not disclose any information identifying the client's history of alcohol and/or drug abuse unless: by written authorization by the client; by written court order; or the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation process. (Federal Law references 42 U.S.C. 290 dd-3 – Federal Regulation reference CFR, Part 2)

I understand that I have the right to request in writing that ***SAGE*** restrict how my protected health information is used to carry out treatment, payment, or health care operations. I understand that ***SAGE*** is not required to comply with my request.

I understand that I have the right to revoke in writing this authorization to release my protected health information.

_____	_____	_____
Client Name	Client Signature	Date
_____	_____	_____
Legal Representative Name	Legal Representative Signature	Date
_____	_____	_____
Witness Name	Witness Signature	Date