5371 W Franklin Road
Boise, ID 83705
info@peerrecoverysupports.com
208.352.0535

DUAL RELEASE OF INFORMATION/AUTHORIZATION

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

_____ (Agency/Provider) ____ (initials)

and ***Peer Recovery Supports of Idaho, LLC*** ____ (initials).

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

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, as well as the Health Information Portability and Accountability Act (HIPM) of 1996, 45 CFR Parts 160 and 164 Subparts A and E, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent any time, by either written or verbal notification, except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: _____

_____ _____
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.*

Staff: A separate form must be completed for each entity/provider.