Authorization Form

This form when completed and signed by you, authorizes My Brother's House to release protected information from your clinical record to the person you designate.

I authorize Ron Yocca, executive director of My Brother's House Recovery Services, or his designees at the organization, to release information about my status and functioning as a resident of My Brother's House from my entry into the program until the present.

This information should only be release to _____. I am requesting Mr. Yocca to release this information for treatment coordination purposes. I am also requesting that _____ release any information, including assessment treatment plan and progress notes, to Mr. Yocca and his staff such that my progress in recovery can be optimized by a team approach.

This authorization shall remain in effect until _____, or until my residence at My Brother's House has ceased.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of this information and no longer protected by the HIPAA Privacy Rule.

_____ _____

Signature of Patient Date

_____

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to My Brother's House office address. However, your revocation will not be effective to the extent that My Brother's House has taken action in reliance on the authorization.