DELTA CONSULTANTS
OF SOUTH COUNTY, INC.

AUTHORIZATION FOR RELEASE OF INFORMATION

I, (name of Client) ______________________________________ Date of Birth ____________________
(hereinafter "Client") authorize Delta Consultants of South County, Inc. (hereinafter "Provider") to obtain and/or disclose information and/or records regarding behavioral health history obtained in the course of my care with Provider including, but not limited to, assessment, diagnosis, treatment, consultation, recommendation(s) and/or any other professional service provided.

Provider: ___________________________

To: ____

Address: ___________________________________

Phone: ____________________________________

Fax: ______________________________________

This authorization is to obtain from and/or disclose to information required for the following purposes:

☐ Medical	☐ Educational/504	☐ Occupational	☐ Legal
☐ Psychiatric/Clinical	☐ IEP	☐ Vocational	☐ AOD II
☐ Psychological	☐ Speech & Language	☐ Disability	☐ Other: ___________

- I understand that I have a right to receive a copy of this authorization;
- I understand that any cancellation and/or modification of this authorization must be in writing;
- I understand that I have a right to revoke this authorization at any time;

Provider shall not condition treatment upon Client signing this authorization and Client has the right to refuse to sign this form.

Client understands that information used and/or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA, 42 CFR Part II, or Privacy Rules, although applicable Rhode Island law may protect such information.

Client or Parent/Guardian (Print Name): ____

Client or Parent/Guardian (Signature): ___________________________________ Date: ____________

Authorization shall remain valid for one year from the date this release was signed/dated by Client.

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