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. to obtains and/or disclose information regarding behavioral health history obtained in the course of my care with their Providers including, but not limited to, assessment, diagnosis, treatment, consultation, recommendation(s) and/or any other professional service provided.

Delta Provider: _____ Provider/Other: _____

Address: _____

Phone: _____

Fax: _____

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

Check all that may apply:

☐ Medical	☐ Educational/504	☐ Occupational	☐ Legal
☐ Psychiatric/Clinical	☐ IEP	☐ Vocational	☐ AOD II
☐ Psychological	☐ Speech & Language	☐ Disability	☐ Verbal
☐ 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 redisclosure by the recipient and may no longer be protected by HIPAA, 42 CFR Part II, or Privacy Rules, although 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 and dated.