CASA
Court Appointed Special Advocates
FOR CHILDREN
CASA OF TERREBONNE, INC.

A POWERFUL VOICE IN A CHILD'S LIFE.™

P.O. Box 824 • Houma, LA 70361 • 985-876-0250 • Fax 985-876-0286 • casaofterrebonne@live.com

Authorization to Release or Obtain Health Information

(including paper, oral and electronic information)

By signing below, I hereby authorize _____ to release and/or to obtain information with respect to any medical, psychiatric, drug and/or alcohol related conditions obtained during the course of diagnosis and/or treatment to/from the individual(s) or healthcare providers listed below. I understand that information to be used or disclosed pursuant to this authorization form may include information relating to: (1) Acquired Immunodeficiency Syndrome ("AIDS") or Human Immunodeficiency Virus ("HIV") infection: (2) treatment for drug/alcohol abuse; and\or (3) mental or behavioral health or psychiatric care. **I agree to this disclosure.** I understand that my signature below will not have effect on the ability or inability to determine, limit or restrict my treatment. I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and to the best of my knowledge.

Client Name: _____ **DOB:** _____

RELEASE TO / RELEASE OBTAINED FROM		PURPOSE OF DISCLOSURE	TYPE OF INFORMATION TO BE DISCLOSED
OTHER	Name CASA of Terrebonne PO Box 824 Houma, LA 70361 FAX (985) 876-0286 Phone (985) 876-0250 Address PO Box 824 Houma, LA 70361 Supervisor: _____ Advocate: _____	DCFS Child in Need of Care Proceedings; CASA Advocate	I agree that the following records are included in what can be disclosed: 1)Notification of admission and discharge, including all assessments, UDS and hair follicle results, attendance, discharge planning, financial, medical emergencies and summary. 2) Treatment Plan and revisions. 3) Progress and treatment report, including attendance.

The above release, signed by me, may be revoked or revised by me in writing at any time. If not previously revoked, the release will expire **1 year from date of signature** below. This release is valid until _____, 20___ or until revoked by me in writing and submitted to the provider. I understand I have a right to receive a copy of this authorization.

_____ _____

Client Date Witness Date

Disclaimer: I understand that information to be used or disclosed pursuant to this authorization form may include information relating to: (1) Acquired Immunodeficiency Syndrome ("AIDS") or Human Immunodeficiency Virus ("HIV") infection: (2) treatment for drug/alcohol abuse; and\or (3) mental or behavioral health or psychiatric care. **I agree to this disclosure.42 CFR Part 2:** This information has been disclosed to you from records protected by Federal Confidentiality rules (42 C.F.R. Part 2). The Federal rules prevent you from making any further disclosure of this information unless disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R> Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose, the federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient."
Re-Disclosure: Federal law prohibits the person or organization to which disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by written authorization of the person to whom it pertains or as otherwise permitted or required by law.
Photocopy: A photocopy of this authorization is valid as an original.