Family Service ROI EMERGENCY CONTACT

Client Name:

Date of Birth:

(D&A, MH, or HIV-related information cannot be used/disclosed in reliance on this form unless specified explicitly as such. D&A and HIV-related disclosures must be accompanied by disclosure statements required verbatim by federal and state laws.)

I authorize Family Service to disclose my protected health information to the following person or entity (name/agency/relationship/phone number):

_____

- ☐ Continuity and Coordination of Care
- ☐ In Case of Emergency

This authorization covers the following information about me:

- ☐ Treatment Concern
- ☐ Lab Results
- ☐ Medication/Prescription Records
- ☐ Diagnoses and Dates of Services
- ☐ Evaluations and Assessments
- ☐ Crisis/Crisis Support Plan
- ☐ Treatment and Discharge Recommendations

This authorization permits Family Service to release the covered information which it has in its possession. Family Service may release this information to the following person or entity whom I have identified as my Emergency Contact. This authorization also permits the above-named person(s) or entity (ies) to disclose the covered information about me which is in their possession to Family Service immediately upon Family Service's request. I understand that I have the right to revoke this authorization at any time either by verbal or written notification to Family Service, which becomes effective immediately. I understand that Family Service may request that I sign a notification form which will be placed in my record. I may not revoke this authorization to the extent that Family Service has already relied upon it or if it was signed as a condition of obtaining insurance coverage. Family Service is instructed to prohibit re-disclosure by parties receiving this information, but I understand that information used or disclosed under this Authorization could potentially be re-disclosed by the person(s) receiving the information, and may no longer be subject to the privacy regulations provided to me by law. I understand that Family Service may not require that I sign this authorization in order to obtain treatment. I have read this authorization or had it explained to me, and I understand its contents.

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I accept a copy of this authorization: **Yes** or **No** (please circle)

In the absence of revocation, I authorize this release of information to become effective on: _____ and to expire on: _____ (date no longer than 1 year)

_____ _____

Client Signature **Date**

_____ _____

Staff/Witness Signature **Date**