VITALITY UNLIMITED
VITALITY INTEGRATED PROGRAMS
COMPLETE BEHAVIORAL HEALTH

Consent for the Release of Confidential Information

Client Name: _____ Date of Birth: _____

I authorize Vitality Unlimited to share and/or obtain information from the following:

Release to: _____ Phone: _____

Address: _____ City/State/Zip: _____

Email: _____ Fax: _____

Reason for release: _____

I authorize Vitality Unlimited to release my confidential records, including information protected by HIPAA and 42 CFR Part 2, via encrypted email to the person(s) or organization(s) identified in this Authorization. ☐ Yes ☐ No Initials: _____

Initial all applicable boxes. All boxes not initialed will not be released.

Substance Use		Mental Health		Medical		Other	
Assessment w/ ASAM		Assessment w/ LOCUS		Medication		Enrollment/Attendance	
Diagnosis List		Diagnosis List		Diagnosis List		Billing Statements	
ASAM Update		LOCUS Update		Discharge Summary		Scheduling	
Urinalysis/Breath test		CUMHA & CASII				Counseling Reports	
Discharge Summary		Discharge Summary				Progress Notes	

My records are protected under HIPAA (45 C.F.R. Parts 160, 162, and 164) and 42 C.F.R. Part 2, and I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal confidentiality regulations. I understand that signing this authorization is voluntary and that I may refuse to sign without affecting my treatment. I may revoke this authorization at any time in writing; however, revocation will not apply to information already released or as otherwise permitted by law, including an insurer's right to contest a claim. Unless revoked earlier, this authorization will expire one year from the date it was signed. This authorization applies only to records originating from this facility and dated on or before the date of this authorization, unless otherwise specified, and may include information related to sexually transmitted diseases, HIV/AIDS, mental or behavioral health services, and substance use disorder treatment. **I have read and understand this authorization.**

Expiration Date: _____

Client Signature: _____ Date signed: _____

Guardian Signature: _____ Date signed: _____

Please send all requests to Medical Records: 1250 Lamoille Hwy Ste. 943, Elko. NV. 89801
P: (775) 927-1684 **F:** (775) 389-5833 **E:** records@vitalityunlimited.org