Release of Information

READ FIRST: Before you decide whether or not to let Healing Things share some of your confidential information with another agency or person, an advocate at Healing Things will discuss with you all alternatives and any potential risks and benefits that could result from sharing your confidential information. If you decide you want Healing Things to release some of your confidential information, you can use this form to choose what is shared, how it's shared, with whom, and for how long.

I understand that Healing Things has an obligation to keep my personal information, identifying information, and my records confidential. I also understand that I can choose to allow Healing Things to release some of my personal information to certain individuals or agencies.

I, _____, authorize Healing Things to share the following specific information with:
name

Who I want to have my information:	Name: Specific Office at Agency: Phone Number:

The information may be shared: ☐ in person ☐ by phone ☐ by fax ☐ by mail ☐ by e-mail
☐ *I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by other people.*

What info about me will be shared:	*(List as specifically as possible, for example: name, dates of service, any documents).*
Why I want my info shared: (purpose)	*(List as specifically as possible, for example: to receive benefits).*

Please Note: there is a risk that a limited release of information can potentially open up access by others to all of your confidential information held by Healing Things.

I understand:

☐ That I do not have to sign a release form. I do not have to allow Healing Things to share my information. Signing a release form is completely voluntary. That this release is limited to what I write above. If I would like Healing Things to release information about me in the future, I will need to sign another written, time-limited release.

☐ That releasing information about me could give another agency or person information about my location and would confirm that I have been receiving services from Healing Things.

☐ That Healing Things and I may not be able to control what happens to my information once it has been released to the above person or agency, and that the agency or person getting my information may be required by law or practice to share it with others.

This release expires on _____
Date

I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing.

Signed:_____ **Date:**_____ **Witness:**_____