



H.O.P.E.

Honoring Opportunities for Personal Empowerment

Name of Participant: _____ Medicaid #: _____ DOB: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Participant: _____ SSN: _____

I, the undersigned, authorize H.O.P.E. to release and/or obtain verbal, electronic, or written information indicated below regarding the above named participant, with the following individuals and agencies:

Name/Agency _____

The information released will be used for the following purpose:

- Evaluation
- Job Developing / Job Coaching
- CPP/ELP Planning
- Screening
- Other

Information to be released (check all that apply):

- Social History
- Progress Reports
- Birth Records
- Diagnosis and Evaluations
- Past / Prospective Employers regarding job developing / obtaining – maintaining employment
- Physician's Orders
- Annual Staffing Reports
- Psychological Evaluations
- Psychiatric Evaluations
- Treatment Plan
- Educational Reports
- Discharge Reports
- Other _____

Take &/or use of Photos &/or video &/or media (including artwork) produced for public relations purposes or fundraising: Newsletters, in-house display, community presentations, brochures/printed material, marketing materials, website, press/media coverage.

- Yes No **Permission to use photos/media for all of the above**
- Yes No **Permission to release name with media**

This release is valid until _____. (expiration date).

I understand that I may revoke this consent at any time and that the above named person/agency authorized to receive this information has the right to inspect and copy the information to be disclosed.

It has been explained to me that if I refuse to consent to this Release of Information, the following are the consequences (specify, if any):

Participant's signature: _____ Date: _____

Legal Guardian Signature (if required) _____ Date _____

Relationship, if not participant

If signature is not of participant, indicate legal relationship to participant and legal basis on which consent is given for recipient.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW: I specifically authorize the release of information relating to:

- Substance Abuse
- HIV/AIDS-related information
- Mental Health

Participant's (or legal guardian's) signature: _____

Date: _____ Relationship, if not participant _____