Winston Salem Rescue Mission
Authorization for Release of Information

Clients Full Name:	Date of Birth:	SSN:

The following agency(ies) have my permission to exchange/give/receive/share/re-disclose information and records regarding service delivery planning for the purpose of securing, coordinating and/or providing services for the above named persons. This information is subject to re-disclosure by the recipient. (Please identify all agencies that apply)

☒	Hospital	☒	Substance Abuse Agency	☒	Housing Authority Winston Salem
☐	School District	☐	Job & Family Services	☒	Financial Institution (Bank)
☐	Family Physician	☒	Health Clinic/Department	☒	Sheriff's Office
☒	Mental Health Agency	☒	Social Security Administration	☒	Police Department
☐	Employer	☒	Emergency Contact	☐	Legal Aid
☐	Emergency Contact Phone	☒	Veterans Services	☐	Other:

_____

(Please Print) Agency Name to provide Winston Salem Rescue Mission

_____

(Print Name) of the Winston Salem Rescue Mission Representative

I authorize sharing of the following information if needed by the receiving agency to secure, coordinate, and provide services to the individual: (Mark the box in the corresponding column to each type of information).

☒ Identifying Information (Name, birthdate, sex, race, address, telephone number)

☒	Social Security Number	☒	Case Information	☐	Vocational Assessments	☒	Home Study
☒	Individual Education Plan (IEP)	☐	Social History	☒	Grades & Attendance	☐	Transitional Plans
☒	Treatment/Service History	☐	Family Service Plan	☒	File Evaluation	☒	Medical Information
☒	Psychological Evaluations	☒	Disability Information	☐	Other Medical Information	☐	STD's
☒	HIV and AIDS related diagnosis and treatment	☒	Substance abuse diagnosis and treatment	☐	Other:	☐	Other:

I understand that this "Authorization of Release of Information" shall remain in effect the entire time I am a resident at the Winston Salem Rescue Mission starting on the date of my signature below. I also understand that I may cancel this "Authorization for Release Information" at any time with assistance from a Program Staff Member. I understand this may affect the services I receive at the Winston Salem Rescue Mission and could result in dismissal from the program.

Participant Signature: Authorization Start Date: _____ day of _____, 20_____.

If Revocation Requested: _____ day of _____, 20_____. Participant Signature:

Reason for Revocation: Staff Signature:

ANY INDIVIDUAL OR AGENCY RECEIVING THIS INFORMATION IS PROHIBITED FROM MAKING FURTHER DISCLOSURE OF THIS INFORMATION. IF THIS INFORMATION CONCERNS A PERSON ADMITTED FOR TREATMENT OF ALCOHOL OR DRUG ABUSE, THE CONFIDENTIALITY OF THIS INFORMATION IS PROTECTED BY FEDERAL LAW. FEDERAL LAW REGULATION (42 CFR PART 2) PROHIBITS YOU FORM MAKING ANY FURTHER DISCLOSURES OF THIS INFORMATION EXCEPT WHEN THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION, IF HELD BY OTHER PARTY, IS NOT SPECIFIC FOR THIS PURPOSE. (For WSRM Program Purposes Use Only)

Return completed form to the WS Rescue Mission by delivering to 717 Oak Street facility or by emailing onlineapplications@wsrescue.org or by faxing to 336-232-1687.