2.3b) HRN Peer Recovery Support: Participant Release

AUTHORIZATION FOR RELEASE OF INFORMATION TO THIRD PARTIES

Peer Participant Name:_____ Date of Birth:_____

Many peer participants want other family members such as spouse, parents, siblings and/or certain friends to be involved in their peer support relationship by getting shared information or calling with questions or information. Many also find it beneficial to include Case Managers and/or Legal Guardians. Under the requirements of HIPAA *(Health Information Portability and Accountability Act)*, Hope Recovery Network is not allowed to give this information to anyone without the peer participant's consent. If you wish to have your medical or other information released to family members, friends or medical providers, you must sign this form. Signing this form will only give information to the people listed below.

I (Print Peer Participant Name)_____ **authorize Hope Recovery Network to release my medical information and other information gathered during Peer Recovery Support to the following individual(s):**

1._____ Relation to Peer Participant: _____
(Print Name of Person to Share Information With)

Contact Information: _____

2._____ Relation to Peer Participant: _____
(Print Name of Person to Share Information With)

Contact Information: _____

3._____ Relation to Peer Participant:_____
(Print Name of Person to Share Information With)

Contact Information: _____

Peer Participant Information:

I (Print Peer Participant Name)_____ **understand I have the right to revoke or change this authorization at any time and that I have the right to discuss the protected health information to be disclosed. I also understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient. I am aware I have the right to revoke this consent in writing.**

Peer Participant Signature:_____ Date:_____