**Authorization RECEIVED**

Date: _____

Staff Name *(Printed)*: _____

MRN#_____

Authorization REVOKED on: _____

❑ Verbally by client ❑ In writing by client

Staff Signature: _____

# BEHAVIORAL HEALTH AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ (Last Name) _____ (First Name) _____ (MI) Date of Birth: _____

The following person or organization is authorized to: ❑ DISCLOSE ❑ RECEIVE the specified information

Name:

Street Address:

City, State Zip:

Phone Number: | Fax Number:

**This information is to be used for the following purpose(s) only:**

❑ Disability Claim ❑ Educational ❑ Treatment*, Payment, Healthcare Operations

❑ Family Communication (must specify what information is to be shared below) ❑ Attorney/Legal ❑ _____

**The specific information to be released/disclosed as specified below:**

❑ Written & verbal exchange of information

❑ Verbal exchange of information only ❑ Written exchange of information only

**Type of information to be shared:** **❑ Full Service Record, including Substance Use Disorders Services ~OR~**

- ❑ Developmental Disability Records
- ❑ Educational Records
- ❑ General Medical Records *(including lab results)*
- ❑ Information about Child Abuse & Neglect
- ❑ Information Necessary to Arrange Transportation
- ❑ Information Necessary to Deal with an Emergency
- ❑ Information about Sexual Assault
- ❑ Information about Sexually Transmitted Diseases
- ❑ Information about HIV/AIDS-related Testing *(including the fact that an HIV test was ordered or reported, regardless of whether the results of such tests were positive or negative)*
- ❑ Mental Health Assessment
- ❑ Mental Health Progress Note
- ❑ Mental Health Discharge Summary
- ❑ Psychiatric Assessment
- ❑ Psychiatric Progress Notes
- ❑ Psychiatric Discharge Summary
- ❑ Substance Abuse Assessment
- ❑ Substance Abuse Progress Notes
- ❑ Substance Abuse Discharge Summary
- ❑ Urinalysis and/or Swab Results
- ❑ Other:

*I understand Lifeways has an integrated health record which allows mental health staff access to information related to substance use or treatment or any other services I receive from Lifeways; I am therefore authorizing Lifeways staff members who need access to my protected health information to access the minimum necessary information in my record for such purposes. This is with the assurance that my substance abuse treatment information will not be reviewed in detail and the fact that I am receiving substance abuse treatment will not be disclosed to other programs outside of Lifeways without my explicit written authorization unless required by law.*

I understand I may revoke this authorization at any time by notifying Lifeways in writing or verbally, except to the extent that information has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date:_____. If I fail to specify an expiration date, this authorization will expire in one (1) year.

*I have read and understand the terms of this Authorization to Disclose, Receive, and Use Protected Health Information. By my signature below, I voluntarily authorize disclosure, receipt and use of my protected health information as indicated above. I understand that the information disclosed using this authorization may be subject to re-disclosure and will no longer be protected by federal law. I understand that I may be denied services if I refuse to consent to disclosures for purposes of treatment, payment, healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.*

**Signature of ❑ Patient or ❑ Legal Representative:** **Date:**

**Name of Guardian/Legal Representative (if applicable) *(Please Print)*:** **Relationship to Patient:**

**Witness Signature:** **Date:** **Time:**

*Substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 and 164, and cannot be disclosed without written consent unless otherwise provided by the regulations. The federal rules restrict any use of alcohol and drug treatment information released for criminal investigations or prosecution purposes.*

**Treatment includes, but is not limited to, care coordination and case management services.*

(06/2021)