Authorization RECEIVED

Date: _____

Staff Name *(Printed)*: _____

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:

❑ Continuity/Coordination of Care ❑ Educational ❑ Disability Claim

❑ Family Communication ❑ 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. Refusal to sign this authorization will not adversely affect a person's ability to receive services.

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

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

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

Information disclosed from any alcohol and drug abuse treatment records is protected by federal confidentiality rules (42 CFR part 2 and 45 CFR parts 160 and 164). Federal rules prohibit anyone from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of alcohol and drug treatment information released for criminal investigations or prosecution purposes.