180 Behavioral Health, PLLC

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name _____ Date of Birth_____

Client Medical Record # ____N/A_____ Client SS # (Optional)_____

I /We, _____ hereby authorize:

(Client or Personal Representative)

_____**180 Behavioral Health, PLLC**_____to disclose and receive specific health information

(Name of Provider/Plan)

from the records of the above named client to/from: _____

(Recipient Name/Address/Phone/Fax)

for the specific purpose(s): Coordination of Behavioral and/or Medical Health services based on client best interest and the coordination of services to facilitate a continuum of care.

Specific information to be disclosed: Diagnoses, history, assessments, medical assessments, medication information, financial information (billing purposes only), evaluations, session notes, substance abuse information and drug screens (if applicable), history, treatment compliance and attendance, testing materials and results, family history with regard to substance abuse and mental health information.

I understand that this authorization will expire on the following date (**or automatically after one year**), event or condition:

_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the Revocation Section on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

_____

(Signature of Client) (Date)

_____

(Signature of Parent/Guardian and relationship) (Date)

_____

Signature of Staff

DHHS-1000 (1/03) Authorization to Disclose Health Information