

**Authorization to Release Protected Health Information  
From Mental Health, Substance Use, and/or Medical Records**

**REQUIRED:** Full Name and complete address (Date of Birth or SSN should be completed for verification)

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Patient Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_\_ Last Four Digits of Social Security Number: \_\_\_\_\_

**REQUIRED:** Bowen Center location and person/place that can receive information (must include minimum address or phone number)

I authorize the following Bowen Center location(s): ☐ Outpatient Office(s) ☐ Inpatient Psychiatric Unit  
☐ Bowen Recovery Center ☐ Bowen Health Clinic

to disclose the following health information to:

\_\_\_\_\_  
(Name of person and/or organization disclosure is to be made to) Relationship (Phone number)  
\_\_\_\_\_  
(Address of person and/or organization disclosure is to be made to) (Fax number)

☐ I authorize the exchange of information from the person / organization listed above to the Bowen Center (optional).

**Date(s) of Treatment/Services to Release** (optional): ☐ All dates **OR** (From) \_\_\_\_\_ (To) \_\_\_\_\_

**REQUIRED:** Select all information that can be disclosed below:

<input type="checkbox"/> All Records	<input type="checkbox"/> Psychological Testing Reports	<input type="checkbox"/> History and Physical Examination
<input type="checkbox"/> Psychiatry (MD/APN) Progress Notes	<input type="checkbox"/> Psychiatric Evaluations	<input type="checkbox"/> Transfer/Termination/Discharge Summary
<input type="checkbox"/> Therapy/Counseling Progress Notes	<input type="checkbox"/> Medications/Dosing	<input type="checkbox"/> Attendance Documentation
<input type="checkbox"/> Health Clinic Office Visit Notes	<input type="checkbox"/> Lab/Diagnostic Results	<input type="checkbox"/> Account / Billing/ Financial Information
<input type="checkbox"/> Treatment Plans	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Assessments	<input type="checkbox"/> MD/APN Orders	<input type="checkbox"/> Other: _____

**REQUIRED:** The purpose of the disclosure authorized above is: [Check ONE specific purpose(s) for disclosure.]

<input type="checkbox"/> Progress Reporting	<input type="checkbox"/> To Communicate with a Third-Party Payer/Insurance
<input type="checkbox"/> To Provide Information to Family / Caregiver	<input type="checkbox"/> For Permission to Return to Work / School
<input type="checkbox"/> To Communicate with Other Treatment Providers	<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> To Respond to a Request for Information	<input type="checkbox"/> Other (specify): _____

**REQUIRED:** If no expiration date or event is listed, I understand this authorization will expire 180 days from date of signature.

**This authorization will expire on:** \_\_\_\_\_, 20\_\_\_\_ **OR at the end of a specific event:** \_\_\_\_\_

I understand that certain information in my record may be protected by 42 CFR Part 2 which governs confidentiality of substance use disorder records. 42 CFR part 2 prohibits unauthorized disclosure of these records. **I also understand that by authorizing the release of my records, content of my medical record may include drug and alcohol use treatment and/or diagnosis, infectious diseases including HIV/AIDS, pregnancy test results, genetic test results, and mental health information.**

I understand that I may revoke this authorization at any time by notifying the Bowen Center Medical Records Manager. I understand that if I revoke this authorization, it will not have an effect on information used or disclosed by Bowen Center prior to my action to revoke. I also understand that I cannot revoke this authorization if drug or alcohol treatment has been ordered by the Court as a condition of my sentencing. I understand that I may refuse to sign this authorization and that my refusal to sign may affect my ability to obtain services or my eligibility to receive insurance payment for my treatment.

I understand that upon request, I may receive an accounting of disclosures of protected health information disclosed by Bowen Center (45 CFR 164.528 and 42 CFR part 2.13). I understand that any information disclosed will be the minimum necessary to satisfy the purpose of the request. To request an accounting of disclosures, please contact the Medical Records Manager by mail at P.O. Box 497, Warsaw, IN 46808.

**REQUIRED:** Patient or personal representative signature, dates, and relationship of personal representative must be completed

Patient Signature / Personal Representative Signature \_\_\_\_\_ Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Personal Representative's Printed Name \_\_\_\_\_ Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

**REQUIRED: For Staff Use Only (SELECT ONE)**

☐ Send requested copies now (charges may apply). ☐ File for reference

C655 (R05) (01/01/20)

**Authorization to Release Protected Health Information  
Bowen Center**

**For Health Information Management Use Only:**

Patient MRN: \_\_\_\_\_ HIMS Initials: \_\_\_\_\_