Authorization for Release of Protected Health Information From Mental Health and/or Substance Abuse Records

THIS AUTHORIZATION IS VALID FOR OUTPATIENT AND INPATIENT MEDICAL RECORDS

Client Name: _____ Date of Birth: ____/____/____

Client Address: _____ City: _____ State: _____ Zip: _____

Phone Number: ( ) _____ Last Four Digits of Social Security Number: _____

I authorize Bowen Center to disclose the following specific health information to:

_____

(Name of person and/or organization disclosure is to be made to) *(Relationship)*

_____

(Address of person and/or organization to which disclosure is to be sent)

( ) _____ ( ) _____

(Phone number) *(Fax number)*

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

Date(s) of Treatment/Services to Release: *(From)* _____ *(To)* _____

Client: **CHECK MARK** all permitted disclosures that apply.

***If all records is selected, the following information will be disclosed (if applicable): Treatment Plans, Assessments, Progress Notes, Medications, Lab Results, Psychiatric Evaluations, History and Physical Exams, Transfer/Discharge Summary, and Psychological Reports.**

☐ *All Records	☐ Lab Results	☐ Attendance Documentation
☐ Treatment Plans	☐ Psychiatric Evaluations	☐ Account Balance / Billing Information
☐ Assessments	☐ History and Physical Examination	☐ Status Update
☐ Progress Notes	☐ Transfer / Termination / Discharge Summary	☐ Other: _____
☐ Medications	☐ Psychological Testing Reports	☐ Other: _____

Information may be communicated <u>verbally</u> and *(check all methods that are acceptable)*:

☐ Printed ☐ Electronically ☐ In a summary document

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

☐ Progress Reporting	☐ To Communicate with a Third Party Payer (insurance)
☐ To Provide Information to Family / Caregiver	☐ To Obtain Insurance
☐ Respond to Request for Information	☐ For Permission to Return to Work / School
☐ To Communicate with Other Treatment Providers Involved in my Care (i.e. family doctor)	☐ Other (specify): _____

I understand that the information used or disclosed is protected by 42 CFR Part 2 which governs confidentiality of substance use disorder records and by 42U.S.C.290dd-2(g). **I also understand that by authorizing a release of my records, content of my medical record may include drug and alcohol use treatment and/or diagnosis, infectious diseases including HIV/AIDS and other personal information.** I understand that I may revoke this authorization at any time by notifying the Bowen Center Privacy Officer. 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 a complete list of entities and individuals who have received my protected health information. I understand that any information disclosed will be the minimum necessary to satisfy the purpose of the request. To request and accounting of disclosures list, please contact the Medical Records Manager by mail at P.O. Box 497, Warsaw, IN 46808.

I understand this authorization will expire on (not to exceed 180 days): _____ **, 20** _____ **OR at the end of a specific event (i.e., completion of substance abuse treatment program, completion of court-ordered group sessions, etc.):** _____

_____ _____

Client Signature / Personal Representative Signature Date Relationship to Client

_____ _____

Personal Representative's Printed Name Witness Signature Date

For Clinician Use Only *(CHECK ONE)* ☐ Send requested copies now (charges may apply). ☐ File for reference

FOR PRIVACY OFFICE USE ONLY	**Client MRN:**	**HIMS Initials:**