NRBH AUTHORIZATION AND CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

I, (PRINT CLIENT NAME) _____ Date of Birth _____, hereby authorize North Range Behavioral Health to release and receive information to coordinate my care by communicating all necessary protected health information in the provision of mental health and/or substance abuse services, and services to children and families.

Information to be released or requested: (Check every box applicable.)

☐ **All medical and mental health treatment records which includes mental health condition and treatment, for all dates of treatment:** Including, but not limited to ☐ clinical charts, ☐ office notes, ☐ test reports, ☐ test data, ☐ physician notes, ☐ notes of Progress-to-Date, ☐ consultation reports and notes, ☐ outpatient records, and ☐ correspondence related to clinical matters.

☐ **Verbal communications:** Including communication either verbally or in writing with the person(s) or entity(ies) listed below, regarding all the released information available, including information contained in treatment records as described above, and is authorized to give opinions and answer questions.

☐ **Drug abuse or alcohol abuse, which includes, if any, alcohol and substance abuse condition and treatment information.** Includes all information regarding any assessment, diagnosis, referral, history, or discussion of drug abuse or alcohol abuse.

☐ **Other:** _____

I understand that my records are protected under federal regulations, including HIPAA and 42 C.F.R. Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that the recipient of this information may in some circumstances re-disclose it and the information may then no longer be protected by HIPAA. I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it, and that my revocation must be in writing. I also understand that NRBH will release information to third party payer sources for the sole purpose of billing for my treatment. This disclosure is for the purpose of ☐ **Treatment,** ☐ **Payment,** ☐ **Operations, or** ☐ **Other.** If "Other" is checked, regardless of whether additional purposes are also checked, this form is a HIPAA compliant Authorization. As such, the Center may not condition treatment, payment, enrollment, or eligibility for benefits on your signing this Authorization. You are entitled to a copy of this Authorization. Please ask for a copy if one is not offered to you.

Information to be released to or from:

Name of agency or person — Address/Telephone

_____

_____

_____

NOTICE: If during the course of your treatment you choose to disclose information concerning Human Immune Deficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), that information may be contained in the records released to the above named individual or agency.

_____ _____

SIGNATURE OF CLIENT OR PERSONAL REPRESEN TATIVE **DATE**

_____

If a personal representative is making this request, print name, legal authority and relationship to client

_____ _____

WITNESS SIGN ATURE **DATE**

This consent expires upon and cannot be used past the following date: (Not to exceed one (1) year): _____

I hereby revoke this consent to Release/Authorization for Information.			
Consumer Signature	Date	Witness Signature	Date

Revised 07-15-09