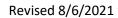


AUTHORIZATION TO RELASE PROTECTED HEALTH INFORMATION

Patient Name:		
Date of Birth:		
Contact Number:		
By completing this form, I am autinformation (PHI) between:	horizing the excha	ange of my Protected Health
The Collective Integrated Behavio [Enter address here]	oral Health	
Name of person or entity:		
Address:		
City/State:		
Phone:		
Fax:		
Email:		
Initialing below signifies my conser	nt to disclose each	of the following type(s) of information:
Substance use Psychiatric _	HIV/AIDS	Medical
Treatment dates authorized:		_
Please release the following:		
Intake Assessment		
Physical Examination		Dates of Treatment
Discharge Plan / Care Plan		Discharge Summary
Substance Use Records		Medication Record
Progress Notes		Entire Record
Lab Results		Other / Clearly specify below
Psychosocial Assessment		

Purpose: This information may be used or disclosed in connection with continuing





care/treatment/care coordination, legal purposes, payment/billing, school, employment, or disability purposes.

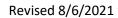
If the purpose is other than as specified above, please specify:	
If for legal purposes, please specify reason (REQUIRED):	



Authorization:

I certify this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except when action has already been taken to comply with it. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure. Refer to the Notice for Privacy Practices regarding authorized disclosures. A legible copy of the Authorization, or my signature, thereon may be used with the same effectivenes as an original. Any information protected by Federal Regulations governing confidentiality of substance use disorder patient records (42 CFR Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure. The facility is not liable for such re-disclosures.

authorization for such re-disclosure. The facility is not liable for such re-disclosures.
This consent expires 180 days after signing unless otherwise specified. If applicable, provide alternate expiration date (less than 180 days from today):
Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the facility. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.
Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.
Redisclosure: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections. I will be given a copy of this authorization for my records.
Signature of Patient (Minors 15 and older must sign for self) Date
Signature of Parent (for all parents under age 18). Guardian or Personal Representative Date





Signature of Clinician

Date: