the COLLECTIVE
INTEGRATED BEHAVIORAL HEALTH

Revised 8/6/2021

**AUTHORIZATION TO RELASE PROTECTED HEALTH INFORMATION**

Patient Name: _____
Date of Birth: _____
Contact Number: _____

By completing this form, I am authorizing the exchange of my Protected Health Information (PHI) between:

The Collective Integrated Behavioral Health
[Enter address here]

Name of person or entity: _____
Address: _____
City/State: _____
Phone: _____
Fax: _____
Email: _____

Initialing below signifies my consent 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

_____ Discharge Plan / Care Plan

_____ Substance Use Records

_____ Progress Notes

_____ Lab Results

_____ Psychosocial Assessment

_____ Dates of Treatment

_____ Discharge Summary

_____ Medication Record

_____ Entire Record

_____ Other / Clearly specify below

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): _____

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**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 informaiton 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.

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

_____

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Signature of Clinician Date: