Compass Health Network

AUTHORIZATION OF DISCLOSURE OF PROTECTED HEALTH INFORMATION - Behavioral Health

Patient's Name: _____ Date of Birth: _____

Last 4 Digits of Social Security #: _____ Client #: _____

I authorize Compass Health Network to: ☐ Disclose To ☐ Receive From

Name: _____

Address: _____

City: _____State: _____ Zip:_____ Fax: _____

Date of Services for PHI to be Released: *(must check one)*

☐ All ☐ From (date): _____ To (date):_____

Information to be Disclosed: *(check all that apply)*

☐ Discharge Summary ☐ Intake Information ☐ Treatment Plan

☐ Progress Notes ☐ Psychological Testing ☐ Psychiatric Assessments

☐ Psychological Evaluations ☐ School Records ☐ Family Assessment

☐ Medication Records ☐ Verbal/Written Communication with: _____ ☐

Other: _____

Purpose of Request: *(must check one)*

☐ To help maintain job security while in treatment ☐ To assist in my treatment ☐ At patient's request

☐ To assure coordination of treatment ☐ Aftercare ☐ Other: _____

This authorization becomes effective on _____ and will automatically expire one year from the date of request or sooner as designated. Please specify: _____.

I understand that my drug and/or alcohol treatment records are protected under the Federal Regulations governing Confidentiality and Drug Abuse Patient Records (42 C.F.R. Part 2) and the Health Insurance Portability Act (HIPAA) of 1996 (45 C.F.R., Parts 160 and 164) and cannot be disclosed without written consent unless otherwise provided for by the regulations.

I understand that by signing this authorization, I am allowing the release of my mental behavioral health information. This may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable diseases, and/or alcohol/drug abuse.

I understand that I have a right to revoke this authorization at any time. I must do so in writing and present my written revocation at the office where I am being seen. I further understand that actions already taken based on this authorization, prior to the revocation, will not be affected.

I understand that I have the right to a copy of this authorization.

I understand that authorizing the disclosure of this protected health information is voluntary in most cases. I can refuse to sign this authorization. I will be refused treatment for my refusal to sign if my care is mandatory by Corrections or the Juvenile Justice System. I understand that I may request to inspect or obtain a copy of my record. I understand that any disclosure of information carries the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my protected health information, I can contact the Privacy Officer for Compass Health Network.

PROHIBITION ON REDISCLOSURE OF ALCOHOL AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS: (1) This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65; or(2) 42 CFR part 2 prohibits unauthorized disclosure of these records.

My signature below acknowledges that I have read, understand and authorize the release of my protected health information.

Client Signature Date

Parent/Legal Guardian/Representative Signature Date

Witness Signature Date