Prairie Ridge Integrated Behavioral Healthcare

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I. _____ , DOB _____ , authorize the following release of information:

[ ] I approve this release to be reciprocal.

Name of Party to Release Information: _____

Address: _____

Phone Number: _____ FAX Number: _____

Name of Party to Receive Information: _____

Address: _____

Phone Number: _____ FAX Number: _____

Description of Information to Disclose: (Indicate below, as a YES response, by checking every category that does apply. Blank or unchecked entries would indicate a NO response.)

[ ] My name / other personal identifying information.
[ ] Placement screening / assessment / recommendations.
[ ] Alcohol / drug history.
[ ] Mental Health Records.
[ ] Psychological, Psychiatric/Mental Health Assessment/Diag.
[ ] Medical Records.
[ ] Summary of treatment plan / progress / compliance.
[ ] Alcohol / drug-testing results.
[ ] My status as a patient at Prairie Ridge.
[ ] Date of admission.
[ ] Duration of involvement.
[ ] Attendance at individual and/or group sessions.
[ ] Date of discharge/discharge summary.
[ ] Other: _____

Purpose of Disclosure: (Indicate below, as a YES response, by checking every category that does apply. Blank or unchecked entries would indicate a NO response.)

[ ] Facilitate significant other involvement in patient's treatment and/or visitation.
[ ] Obtain corroboration of patient's report of history and current behavior.
[ ] Coordination of treatment services with above-named provider.
[ ] Facilitate legal representation regarding: _____
[ ] Other: _____

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

that I may revoke this consent in writing at any time except to the extent this action has been taken in reliance on it, and that in any event this consent expires automatically as follows:
Specify date, event, or condition upon which this consent expires:

_____
_____

I understand that generally Prairie Ridge may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

☐ Mental Health ☐ SA (Including testing results) ☐ SA (NOT including testing results) ☐ HIV related

Signature of Person Authorizing Disclosure:

_____ _____ _____
Name: (Patient Name) Date: Time:

Signature of Witness:

_____ _____ _____
Name: (Staff Name) Date: Time:

Prohibition on Redisclosure on Alcohol or Drug Treatment Information:
This notice accompanies a disclosure of information concerning a patient in alcohol/drug abuse treatment, made to you with consent of such patient. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict the use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Prairie Ridge Integrated Behavioral Healthcare
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