LEGACY BEHAVIORAL HEALTH SERVICES

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Consumer Name: _____ CID #:_____ Date of Birth:_____

1. Legacy Behavioral Health Services (LBHS) is authorized to: _____disclose to and/or _____obtain from:

Name: _____ Relationship: _____

Address: _____Phone number: _____

Please check all that apply: _____ discharge summary ____hisotry/physical ____psychiatric treating ____psychological evaluation

_____aftercare plan _____family information _____treatment plan _____verbal information/patient progress

_____other: (specify)_____

2. **For the following purpose: (*check all that apply*):** _____aid in treatment _____family involvement _____school involvement

_____discharge planning _____follow-up _____personal _____EAP referral _____legal matters

_____other: (specify)_____ _____Send family program packet and questionnaire (where applicable)

_____
Initials

I authorize the disclosure of alcohol or drug abuse information, if any. (Please see paragraph 2 below). If I am a minor my parent/guardian/court-ordered custodian and I BOTH must inital here in order for the information to be released.

_____
Initials

I authorize the disclosure of information, if any, concerning testing for HIV (Human Immunodeficiency Virus) and/or treatment for HIV or AIDS (Acquired Immune Deficiency Syndrome) and any other conditions.

1. ***I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws (except as set forth in paragraph 2below).***
2. ***I understand that, pursuant to 42 C.F.R Part 2, alcohol and drug abuse records that I authorize to be disclosed pursuant to this document may not be further re-disclosed without my written consent, except by a court order that complies with the preconditions set forth at 42 C.F.R. 2.61 et seq., or the other limited circumstances specifically permitted by 42 C.F.R. Part 2.Any individual that makes such a disclosure in violation of these provisions may be reported to the United States Attorney and be subject to criminal penalties.***
3. ***I understand that DBHDD or my healthcare provider will not condition my treatment, payment, or eligibility for anyapplicable benefits on whether I provide authorization for the requested release of information.***
4. ***I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and State law, and understand that my authorization will remain in effect for: (PLEASE CHECKONE)***
   _____one (1) year OR _____(2) the period necessary to complete all transactions on matters related to services provided tome.
5. ***I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may revoke this authorization at any time as shown in the space below.***
6. ***I also understand that if I discontinue services, that this authorization is no longer valid.***

_____

Signature of Individual/Consumer/Patient/Applicant Print Name Date Time am/pm

_____

OR **Signature of other person authorized to sign for Individual(check one):** Print Name Date Time am/pm

_____Parent _____Guardian _____Court-appointed Custodian of Minor _____Agent designated by Individuals PAD

_____

Witness Print Name Date Time am/pm

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN
I hereby revoke this authorization,

_____

Date this authorization is revoked **Time am/pm** **Signature of Individual or Legally Authorized Representative**