Authorization for Use or Disclosure of Behavioral Health Record

Please complete both sides.
Failure to provide all information may invalidate this Authorization.

Patient Information:			
Last Name:	First Name:	MI:	DOB:
Address:	City:	State:	Zip:
Telephone:	Email:		

Release From:	***Release To:***
I hereby authorize the following person/entity to release my information: Person/Entity:_____ Address:_____ City/State/Zip:_____ Phone:_____ Fax: _____	My Behavioral Health information may be released to: Person/Entity:_____ Address:_____ City/State/Zip:_____ Phone:_____ Fax: _____

Purpose:

The release is authorized for the following purpose(s):

___Continuing Treatment ___Legal ___Insurance ___Personal Use ___Other: _____

Information to Release:

Date Range of Records Requested:	From:	To:

Please initial next to each type of information requested:

___Summary Letter____Attendance Record____Medications List____Contact Log
___Initial Evaluation____Treatment Plan____Progress Notes____Psychotherapy Notes
___Self-Care Management Plan____Results of Diagnostic Testing____Other

Joint/Family Counseling: Information disclosed may include notes/records from joint/family counseling sessions, if any. Initial one of the following statements:
I do authorize release of information from joint/family counseling sessions: _____
I do not authorize release of information from joint/family counseling sessions: _____

Sensitive Information:

I understand the information to be released or disclosed may include information that will reveal that Behavioral Health services have been/are being provided to me. This information may include but is not limited to specific details about discussions or conversations involving physical/sexual abuse, substance abuse, and/or mental illness. My initials on this line demonstrate my acknowledgement and authorization to release or disclose this type of information: _____

Delivery Instructions:

___ Mail___Fax records directly to person/entity specified above
___Call patient when records are ready for pick up.
___Patient/Representative authorizes_____to pick up the copies.
___Other instructions: _____

Expiration:

Without my written revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, or one year from the date signed, unless otherwise specified:_____.

Notice of Rights:

1. If I refuse to sign this authorization, my refusal will not affect my ability to obtain treatment.
2. I may inspect or obtain a copy of the health information requested in this authorization.
3. I may revoke this authorization at any time in writing, signed by me or on my behalf, and delivered to Borrego Health, Privacy Office, P.O. Box 2369 Borrego Springs, CA 92004.
4. If I revoke this authorization, the revocation will not have any effect on any actions taken prior to Borrego Health's receipt of the revocation.
5. I have a right to receive a copy of this authorization.
6. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by the federal privacy rule (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

Signature:

Signature of Patient or Legal Representative: _____
Date:_____Relationship (if Legal Representative): _____

Signature of Provider*:_____Date: _____
*Provider for this authorization refers only to a licensed Psychiatrist, Psychologist, Social Worker, or Marriage and Family Therapist who approves this patient/patient representative initiated request for release of patient records.