Crosspointe Family Services

1363 Fillmore St, Twin Falls, ID 83301
Office: (208)-736-7090 Fax: (208)-736-7089

Behavioral Health-Release and/or Exchange of Protected Health Information

Patient's Name:_____ Date of Birth:_____

Parent/Guardian/Foster Parent Name:_____

I authorize:

Name:_____

Address: _____

Phone: (_____)_____ Fax: (_____)_____

(Initial either or both as needed.) **[ ] to release PHI information to: [ ] to obtain PHI information from:**

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A. The confidential Protected Health Information (PHI) to be released:

___ Psychiatric test results	___ CBRS (PSR) Treatment Plans	___ Speech therapy reports
___ Psychological Test results	___ GAIN Assessment	___ Case Management Plans
___ Diagnostic Assessments	___ Therapy Progress	___ Billing Information
___ Developmental assessments	___ Medical History/Physical	___ Aftercare Plans/Reports
___ Clinical Treatment Plans	___ Occupational therapy reports	___ Coordination of Care Communications*
___ Behavioral health therapy reviews	___ Pharmacy/Medication List	___Appointment Communications#

*Any verbally released information regarding treatment. #Any verbal information regarding scheduling appointments/no shows.

___ Other: _____

Such information may be freely exchanged by the above-designated parties in writing (by fax, electronic mail, or other electronic file transfer mechanisms), by postal delivery, in person, or by telephone, but such exchange is limited to the agencies or people listed and to necessary information related to care and treatment of the client, unless otherwise specified. I release the parties involved from all liability arising from such exchange of PHI records. I accept full responsibility for any and all action or consequences that may directly or indirectly result from the release of my PHI. I understand that this "Release of PHI" is intended to allow me to provide my informed consent for an exception to my confidentiality and the protection of my privacy guaranteed under federal law, including, but no limited to, the Federal Privacy Act (P.L. 93-579), the Freedom of Information Act (P.L. 93-502), Code of Federal Regulations (42, Part 2), and HIV records under Public Health Law article 27-F.

B. Effective date of authorization:

This authorization takes effect the day that you sign it and terminates on: _____ or one year from the date it is signed.

I understand that I have a right to revoke this authorization at any time. I can refuse to sign this authorization. I need not sign this authorization in order to receive treatment. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Crosspointe Family Services. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company as law provides my insurer with the right to contest a claim under my policy.

_____ _____

Participant/Guardian/Foster Signature Date Witness Signature Date