COLLABORATIVE PRIMARY & PSYCHIATRIC HEALTHCARE

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HIPAA MENTAL HEALTH
MEDICAL RECORDS RELEASE FORM

The purpose of this form (the "Authorization") is to obtain your consent to release your protected health information or mental health medical records. Please complete all sections of this form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Patient Information

Full Name: _____
SSN: _____ DOB: _____
Address: _____
_____
Phone Number: _____ Email: _____

Authorized Party

I, the Patient named above, give permission to the following "Authorized Party" to release my protected health information or mental health medical records (collectively referred to as "PHI") in accordance with the terms of this Authorization form:

Practice Name: _____
Address: _____
Phone: _____

Disclosure

I, the Patient named above, give permission to the Authorized Party to release my PHI to the following party:

Name: _____
Address: _____
Phone: _____

I give permission to the party described above to receive my PHI as described in this Authorization form. I understand that the person(s)/organization(s) listed above may not be covered by state and/or federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Method of Disclosure

I, the Patient named above, give permission to the Authorized Party to disclose my PHI via the following methods (*check all that apply*):

- ☐ Pick up at the following clinic/facility address: _____
- ☐ Fax to the following number: _____
- ☐ Mail to the following address: _____
- ☐ Email to the following address: _____
  *(*note that email may not be a secure method of communication)*
- ☐ Other (*specify*): _____

I authorize release of my PHI in the following formats (select all that apply):

- ☐ Electronic copy or access via web portal
- ☐ Hard Copies

Protected Health Information

_____ ***(Patient/Representative Initials)*** I, the Patient named above, give permission to the Authorized Party to disclose the following PHI and mental health records (*select all that apply*):

- ☐ **ALL HEALTH INFORMATION**
- ☐ Assessment
- ☐ Diagnosis
- ☐ Treatment Plan /Summary
- ☐ Medication & Management
- ☐ Nursing /Medical Information
- ☐ Psychosocial Evaluation
- ☐ Psychological Evaluation
- ☐ Psychiatric Evaluation
- ☐ Current Treatment Update
- ☐ Presence/Participation in Treatment
- ☐ Progress in Treatment
- ☐ Educational Information
- ☐ Discharge/Transfer Summary
- ☐ Continuing Care Plan
- ☐ Demographic Information
- ☐ Other (specify): _____ _____

Your initials are required to release the following types of PHI. Please initial next to the categories below that you give authorization to release. If you do not wish to release these types of information then do not initial below.

Initial

_____ Alcohol, drug, and substance abuse records
_____ Genetic information (including genetic test results)
_____ HIV/AIDS test results and treatments

* *Please note that this Authorization form does NOT include psychotherapy notes – if requesting, you must fill out a separate authorization form.*

Dates

I would like the PHI described above to be released for the following dates (*select one*):

- ☐ All dates
- ☐ Only those records from the start date of: ___/___/___ to the end date of: ___/___/___

Purpose

The reason for disclosure of the PHI is (*select all that apply*):

- ☐ At the patient's request
- ☐ To receive payment
- ☐ Continuity of care
- ☐ School
- ☐ Employment
- ☐ Legal purposes
- ☐ Personal use
- ☐ Insurance
- ☐ Disability determination
- ☐ Other (*specify*): _____

Termination

This Authorization will terminate (*choose one*):

- ☐ Upon sending a written notice of revocation to the Authorized Party
- ☐ On the following date: ____/____/____
- ☐ Other (*specify*): _____

Revocation

I, the Patient described above, understand that I have the right to revoke this Authorization any time. If I revoke this Authorization, I understand that I must do so in writing at the Authorized Party's address as listed on page one of this Authorization. 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, Medicaid, and Medicare.

Acknowledgment of Rights

By signing this Authorization form, I, the Patient described above, understand that:

a. I have the right to revoke this Authorization, in writing at any time, except where uses or disclosures have already been made based upon my original permission.

b. Uses and disclosures already made based upon my original permission cannot be taken back.

c. Once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

d. Completing this Authorization form is voluntary and that treatment will not be denied if I refuse to sign this form.

e. I will receive a copy of this Authorization after I have signed it.

f. I may inspect or copy the information to be used or disclosed.

g. A copy of this Authorization is as valid as the original.

h. My treatment, payment, enrollment, and/or eligibility or benefits is NOT in any way conditioned upon nor will be affected by my signing or refusal to sign this form.

***

I certify that I have read and fully understand the statements above on all pages and I consent fully and voluntarily to its contents.

Patient Signature: _____
Print Name: _____
Date: _____

* If patient is unable to sign on behalf of self, then complete the following section:

Representative Signature: _____

Print name: _____
Date: _____
Relationship to Patient: _____
(e.g., parent, spouse, representative, guardian, etc.)

Reason:

- ☐ Minor
- ☐ Incapacitated
- ☐ Other (specify): _____

** If you are a legal representative of the person whose information you are requesting, you must provide documentation proving your valid legal authority to request this information (e.g., power of attorney, healthcare surrogate form, court order, appointment of a guardianship, order appointing personal representative, letter of administration, etc.).*

Witness

Signature: _____
Print Name: _____
Date:_____
Address: _____
_____
_____