BLUEWATER BEHAVIORAL HEALTH

4400 East Highway 20, Suite #313, Niceville, FL 32578* Phone (850) 797-2598 * Fax (850) 807-5127

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

1. Patient Information:

Name: _____ DOB: _____ SSN#: _____

2. Authorization: I authorize the following third parties to disclose the above listed patient's protected health information in the manner described below in section 3.

Name of Third Party to Provide/Receive Information: Bluewater Behavioral Health, Inc.

Name of Third Party to Provide/Receive Information:

Name: _____ Phone:_____ Fax: _____

Address: _____

City/State/Zip Code: _____

3. Scope of Authority: I authorize the disclose of my protected health information to the above-named individual/entity as follows: (check only one)

_____ I authorize the disclosure of ANY protected health information (except psychotherapy notes) that the above-named individual/entity may request. If applicable, this information may include information pertaining to chronic diseases, behavioral health conditions, communicable diseases including HIV or AIDS and/or genetic information.

_____ Also include any alcohol and substance abuse records, if applicable (indicate by initialing). *** This authorization will not apply to alcohol or substance abuse information unless specifically authorized above.

_____ I authorize the disclosure of ONLY the following protected health information to the above-named individual/entity:

_____

4. **Purpose:** This authorization is made:

_____ At my request.

_____ For the following purpose(s): _____

5. **Expiration and Revocation**.

Expiration: This authorization with expire on _____ (1 year) or _____ at the end of treatment.

Revocation: I understand that I may revoke this authorization at any time by notifying Bluewater Behavioral Health, Inc in writing. Revocation will not apply to records already furnished in reliance upon this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules or privacy laws.

6. **Signature**. I am making this authorization voluntarily and have had full opportunity to read and consider the content of this authorization.

Signature of Patient/Guardian: _____ Date: _____

Witness Name: _____ Signature of Witness: _____