Barnabas Behavioral Healthcare, LLC

409& 410 Evelyn Drive, Columbia SC 29210
Office: 803.216.0850
Fax: 803.216.0420
www.barnabashealthcare.com

Glenn P. Zaepfel, Ph.D.
Linda C. Zaepfel, APRN, BC, LISW-CP
Megan N. Zaepfel, APRN, BC
David C Jones, APRN, BC
Stephanie Harvey, LISW-CP
Jon Wright, LPC
Laura J. Miller, LISW-CP, MAC, CACII
Thomas E. Cromer, LISW-CP
Nola C. Burnette, LISW-CP
Rachel Lewis, LISW-CP
Allison Shipman, LISW-CP

Specializing in the Strategic Integration of Medical and Psychological Care

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Regarding Patient- COMPLETE IN FULL

Name- Last, First, Middle		Date of Birth
Street Address		
City	State	Zip
Last 4 of SSN		Telephone #

2. Records Released From:

Provider Name(s):

Barnabas Behavioral Healthcare, LLC
409 Evelyn Drive
Columbia, SC 29210

Telephone 803-216-0850
Fax 803-216-0420

3. Records Released To:

Street Address	
City State Zip Code	
Telephone #	Fax #

4. Reason for Disclosure:

- ☐ Further Medical Care/Referral
- ☐ Changing Provider/Therapist
- ☐ Treatment Planning
- ☐ Medication Evaluation
- ☐ Permission to speak
- ☐ Other
- ☐ Personal
- ☐ Insurance
- ☐ Legal Inquiry
- ☐ Assessment
- ☐ Disability Services
- ☐ Academics

6. Medical Records to be released (Excluding Counseling and Psychiatry)

- ☐ Visit Notes
- ☐ Physical Exam
- ☐ Allergy Records
- ☐ Telephone/Verbal Communication
- ☐ Medication List/History
- ☐ Laboratory Reports
- ☐ Hospital/Referral Report
- ☐ Billing/Coding
- ☐ Letter
- ☐ Entire Record
- ☐ Other_____________________
- ☐ Dates of Treatment/Visit/DX ___________________________

5. Counseling & Psychiatry Records to be released:

- ☐ Psychotherapy Notes
- ☐ Treatment Recommendations
- ☐ Psychiatric Evaluation
- ☐ Termination/Discharge Summary
- ☐ Letter______________________
- ☐ Ongoing Communication________________________________
- ☐ Other____
- ☐ Psychiatric Notes
- ☐ Medication History/ List
- ☐ Billing Coding
- ☐ Intake Summary

7. Privileged Information to be released:

- ☐ STI/STD
- ☐ Drug/Alcohol Abuse
- ☐ HIV/AIDS
- ☐ Interpersonal Violence Incident
- ☐ Developmental Disability
- ☐ Ongoing Communication: _______________________________________
- ☐ Date(s) of Incident/Treatment/Visit: ______________________________
- ☐ Other______________________ ____________________________ ____________________

8. Patient Rights:

I understand that signing this form is voluntary. My treatment, payment, or eligibility for services will not be conditioned upon my authorization of this disclosure. I may revoke this authorization in writing at any time, except to the extent that action has not already been taken as a result of my signing this form. I may revoke this by sending a Request for Revocation of PHI form to the Barnabas Behavioral Healthcare, LLC. I understand that information disclosed under this authorization might be re-disclosed by the recipient and may no longer be protected by privacy laws. I understand that a photocopy or facsimile copy of this authorization shall be considered as effective and valid as the original. Unless otherwise revoked, this authorization will expire on (date): __________________.

If I fail to specify an expiration date or event, this authorization is valid for sixty (60) days from the date of my signature.

I have read and fully understand the above statements and consent to the disclosure of my health record for the purpose and to the extent stated above. By signing this authorization, I am confirming that it accurately reflects my wishes.

____ ______________________________

Patient Signature/ Legal Representative (state relationship & authority to do so) Date