Barnabas Medical Behavioral Healthcare, LLC

409 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
Thomas E. Cromer, LISW-CP
M. Irina Cromer, LISW-CP
Laura J. Miller, MSW,LISW-CP,MAC,CACII
Nola C. Burnette, LISW-CP
Joan M.Burns, DNP,APRN,PMHNP-BC

A Full Service Behavioral Health Practice 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: ☐ **fax** ☐ **mail** ☐ **verbal** ☐ **pick up** ☐ eSend

Name (i.e. Insurance Co., Physician, Self, Parent, translator)	
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______________________
☐Psychiatric Notes
☐Medication History/ List
☐Billing Coding
☐Intake Summary
☐Ongoing Communication__________________________________
☐Other____

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

For Office Use Only

Release Method ☐ Fax ☐ Mail ☐ Verbal ☐ Pickup ☐ Secure eSend

Date PHI Released: _________________
Number of Pages Released: __________ Provider Signature:____