Behavioral Health Associates

6216 Airpark Drive, Chattanooga, TN 37421

Ph: 423-899-0024 Fax: 423-899-5688

Authorization to Release Healthcare Information

Patient's Name: _____ Date of Birth: _____

I authorize Behavioral Health Associates to *(choose one):* **RELEASE / OBTAIN / EXCHANGE** records with:

Name _____ Phone:_____ ___ Fax: _____

Address _____

Records to be Released (45 CFR § 164.508 (c)(1)(i)).

☐ **All Medical Records** ☐ Notification of Treatment ☐Itemized Billing

☐ Progress Notes ☐ Medication Records for Coordination of Care

☐ Lab/Procedure Reports ☐Psychiatric/Psychological Evaluation

☐ Other (including date range limitations):_____

Purpose for Disclosure

☐ Referring Physician ☐ Insurance ☐ Patient Request ☐ Attorney

☐ Disability ☐ Other (please state reason)_____

This authorization shall remain in effect until: _____

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization (45 CFR § 164.508(c)(2)(i)). I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes (45 CFR § 164.508 (c)(2)(ii). I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (45 CFR § 164.508 (c)(2)(iii)). If this authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

_____ _____

Signature of Patient/Guardian *Date*

_____ _____

Witness *Date*