Great Basin Behavioral Health and The Anxiety Treatment Center of Nevada
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Great Basin Behavioral Health
The Anxiety Treatment Center of Nevada

RELEASE OF INFORMATION OR AUTHORIZATION (OPTIONAL)

Client Name: _____ Client DOB: _____/_____/_____

I give my permission for health care information to be exchanged between Great Basin and the following:

_____

Agency/Organization/Person Phone # Fax #

_____

Agency/Organization/Person Phone # Fax #

_____

Agency/Organization/Person Phone # Fax #

Information may consist of (**Check all that apply**):

☐ **All Records** ☐ Progress Notes ☐ Mental Health Evaluations

☐ Discharge Summaries ☐ Treatment Updates ☐ Other_____

- I understand that this disclosure is for the purpose of treatment/coordination of care.
- Great Basin Behavioral Health (GBBH) must offer to and/or provide me with a copy of this authorization.
- I understand that, unless lined through and initialed, information to be released/authorized may include information regarding the following: Substance Use, Psychiatric Conditions/Treatment, HIV/Auto Immune Deficiency Syndrome, or other health related conditions.
- I understand that by releasing this information to other parties, it may not be protected by HIPAA regulations.
- I understand that I may revoke this release/authorization at any time by giving written notice to GBBH, except to the extent that action has already been taken to comply with it. Without such revocation, this release/authorization will expire on ____/____/____ (date), or if left blank, **one (1) year** from the date of my signature.
- I understand I must be given a copy if this is an authorization or release of alcohol and drug information. If applicable, an assessment of the minimum necessary amount of information required has been applied to this release/ authorization.

_____

Signature of Client/Parent/Legal Representative

_____

Print Name and Relationship of Legal Representative (if applicable)

Date Signed: _____/_____/_____