

### RELEASE OF INFORMATION OR AUTHORIZATION (OPTIONAL)

Client Name: \_\_\_\_\_ Client DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Agency/Organization/Person	Phone #	Fax #
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Agency/Organization/Person	Phone #	Fax #
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Agency/Organization/Person	Phone #	Fax #
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Information may consist of **(Check all that apply)**:

- Scheduling/Payment       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: \_\_\_\_/\_\_\_\_/\_\_\_\_