

THE BERT NASH COMMUNITY MENTAL HEALTH CENTER, INC.
Authorization for Release of Protected Health Information
Including that Related to Drug or Alcohol Abuse and Psychiatric Records

I, _____, do hereby consent to and authorize Bert Nash Community Mental Health Center to, as indicated,

obtain from: **release to:** **exchange oral information with:**

_____, _____,
 Name of Person Facility/Organization
 _____, _____, _____,
 Address City State Zip
 _____, the authorized information pertaining to _____.
 Telephone Client

Date of Birth _____ Social Security Number _____

- | BNC to Obtain | BNC to Release | | BNC to Obtain | BNC to Release | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Presence in treatment. (including dates of service) | <input type="checkbox"/> | <input type="checkbox"/> | Medical history and physical examination. |
| <input type="checkbox"/> | <input type="checkbox"/> | Treatment Plan | <input type="checkbox"/> | <input type="checkbox"/> | Medication Record |
| <input type="checkbox"/> | <input type="checkbox"/> | Diagnosis, brief description of progress and prognosis | <input type="checkbox"/> | <input type="checkbox"/> | Physician's orders |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychological tests or projective assessments | <input type="checkbox"/> | <input type="checkbox"/> | Lab, EKG |
| <input type="checkbox"/> | <input type="checkbox"/> | Progress Notes | <input type="checkbox"/> | <input type="checkbox"/> | Medical discharge summary |
| <input type="checkbox"/> | <input type="checkbox"/> | Consultations | <input type="checkbox"/> | <input type="checkbox"/> | Educational records including achievements and assessments. (IEP information, discipline records, school attendance.) |
| <input type="checkbox"/> | <input type="checkbox"/> | Legal Information (including police reports) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Crisis Screening report | <input type="checkbox"/> | <input type="checkbox"/> | Evaluations |
| <input type="checkbox"/> | <input type="checkbox"/> | Custody Evaluation | <input type="checkbox"/> | <input type="checkbox"/> | Substance abuse reports including UA results |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ | | | |

Information is Needed for the Following Purposes:

- To provide ongoing treatment/continuity of care.
- To provide educational services/ school placement or assessment/ coordination of services with authorized school officials
- Legal Proceedings
- Disability Determination
- To coordinate treatment efforts with my family/concerned person
- To coordinate treatment and continuing care efforts with my employer.
- To enable judges, attorneys, probation/parole officers to support treatment goals or make legal decisions on my behalf (Diversion, Probation, Parole)
- Other: _____

READ CAREFULLY: I understand that my medical/behavioral health records are confidential. I further understand that by signing this authorization, I am allowing release of information to the agency or person specified above. Drug and/or alcohol abuse information records are specifically protected by federal regulations. (42CFR Part 2) By signing this authorization, I am allowing the release of all records above, including any drug and/or alcohol information to the agency or person specified above. Federal Regulations prohibit the recipient of the information from making further disclosure without the specific, written consent of the responsible person, or as otherwise permitted by law or regulation. A general authorization for the release of medical or other information if not sufficient for this purpose. This consent may be revoked at any time except to the extent that action has already been taken. This authorization will expire on _____. (If left blank, this authorization automatically expires 90 days after discharge.) This authorization to release information is subject to the following restrictions: _____

_____ Signature of Client	_____ Date
_____ Signature of Parent, Guardian or Legal Representative	_____ Date
_____ Signature of Witness	_____ Date
_____ Relationship to Client	

Reg. ID# _____