AUTHORIZATION FOR USE, DISCLOSURE, AND/OR EXCHANGE OF MEDICAL & MENTAL HEALTH INFORMATION INCLUDING PRIVATE HEALTH INFORMATION UNDER HIPAA AND CONFIDENTIAL ALCOHOL AND SUBSTANCE ABUSE TREATMENT RECORDS UNDER 42 C.F.R, PART 2

Name of Patient: DOB: Day Tel. No.: (____) _____
(Please print full name)

NATURE AND LIMITS OF INFORMATION TO BE DISCLOSED: I hereby authorize **Behavioral Health Clinic (BHC)** to release the following information contained in my provider records, including confidential alcohol and substance abuse treatment records, inclusive of medical, mental health and other identifying information and confidential communications, any medical records and mental health records as described or defined under Maryland statutory or case law, private health information (PHI) under HIPAA, and, if checked off and initialed in the table below, other information pertaining to my treatment at the above-named facility/provider (all hereinafter collectively "information"). This request authorizes the **release, exchange and disclosure** of the following information contained in my files. I specifically request the disclosure or non-disclosure of the following information. **By electing "Yes" or "No" below, the patient is not admitting to the existence of any said records. Specific Releases: (Please check and INITIAL all ~~6~~ items, or as applicable.)**

	Yes	No	Init.		Yes	No	Init.
Admission and Discharge Dates				Progress In Treatment			
Attendance				Aftercare Referrals			
Residential Information				Other:			

It also includes all information from other treatment providers contained in the record unless re-disclosure is specifically prohibited therein by any other provider.

DISCLOSURE TO BE MADE TO/INFORMATION EXCHANGED WITH:

Name: _____

Address_____
_____

Phone Number: _____

PURPOSE OF DISCLOSURE:	Yes	No	Init.		Yes	No	Init.
Engagement In Treatment				In Case of Emergency			
Follow Up Activities				Treatment Planning Decision			
Provide Information about BHC				Other:			

EXPIRATION DATE/REVOCATION: This authorization automatically expires one year from the date signed below unless revoked in writing sooner by the individual authorizing disclosure in written form to the person or entity to whom or which the disclosure is or was to be made. Revocation for criminal justice referred substance abuse clients is prohibited pursuant to the conditions of 42 C.F.R. Part 2 §§ 2.31 and 2.35. I understand I can ask the court to limit re-disclosure thereafter. **REDISLOSURE/WAIVER:** I also authorize the intended recipient to re-disclose and/or use all or part of the information obtained for purposes of Continuance of Care. I understand that the protected information herein may only be re-disclosed to those persons or entities specifically designated herein without further protection under HIPAA, Maryland statutes and federal confidentiality regulations for alcohol and substance abuse under 42 C.F.R. Part 2. **MISCELLANEOUS:** A photocopy or facsimile of this authorization and request for release of information shall be deemed as valid as an original. I understand that information may be released in reliance hereon to the extent revocation has not occurred. I understand that benefits may not be conditioned upon signing this authorization.

_____
Patient's Signature **Date**

_____
Parent/Legally Recognized Representative Sign. * **Date**

_____
Witness Signature **Date**

* By my signature, I attest that I am the legally recognized representative of the above-mentioned patient in accordance with the following:

_____
This authorization is compliant with HIPAA, the Maryland Confidentiality of Medical Records Act and Federal Confidentiality of Alcohol and Substance Abuse Information. If you have any questions, please call The Office of Quality Assurance and Certification at _____.