**Behavioral Health Network (BHN)**
**417 Liberty Street, Springfield, MA 01104**
**413-733-6661**

# AUTHORIZATION TO OBTAIN OR RELEASE PROTECTED HEALTH INFORMATION

**This form Authorizes BHN to Request and/or Release Protected Health Information (PHI) to or from a person or organization outside of BHN.**

**Print Client Name:** _____
**First** **Middle** **Last** **DOB**

**Please Initial Below Where Applicable: (**Must **Initial** One or Both**)**

_____ I authorize BHN to Request my information **FROM** the Person/Place below & have it sent **TO BHN**.
By initialing this selection, BHN can have on-going communication with the recipient below.

_____ I authorize BHN to Release my information **TO** Person /Place Below & have it sent **FROM BHN**.
By initialing this selection, BHN can have on-going communication with the recipient below.

**Name of Person or Organization to whom BHN is exchanging information:**

_____

**Address, City, State, Zip or Fax of the Organization or Person above:**

_____

_____

**Start Date for Authorization**: _____ **End Date of Authorization (1 Year max):** _____

**Documentation Requested from Recipient:**

| | | | | | |
|---|---|---|---|---|---|
| | Physical Health Information | | Psychiatric Notes | | Discharge/Transition Summary |
| | Care Plan/ Treatment Plan | | Last Assessment | | Academic Records |
| Other, Specify: | | | | | |

**Specify Dates for Documentation requested: _____ to**: _____

**Documentation to be Released:**

| | | | |
|---|---|---|---|
| | Psychiatric Notes | | Care Plan or Treatment Plan |
| | Last Assessment | | Discharge or Transition Summary |
| Other Information, Specify: | | | |

**Purpose of Release:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Coordination of Care | | Communication with Family | | Communication with School | | Exchange Medical Records |
| | Provider Request | | Social Security Request | | Other, Specify | | |

**Authorization to Release This Specific Information <u>Requires your Initialing Below</u>:**

| | |
|---|---|
| | Alcohol, Drug or Substance Use Treatment Information |
| | HIV and Sexually Transmitted Disease Information |
| | Information Involving Reproductive Health |

**Additional notes and/or limitations:**

_____

**ACKNOWLEDGEMENT CONCERNING ALCOHOL AND DRUG TREATMENT RECORDS**

I understand that my alcohol and drug treatment records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 (Part 2 Regulations), and the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160 and 164 (HIPAA Regulations), and cannot be disclosed without my signature below, unless the disclosure is otherwise provided for in the Part 2 Regulations and the HIPAA Regulations. I also understand that I may revoke this Authorization at any time except to the extent that action has been taken by the BHN Program(s) in reliance on it.

**Additional Acknowledgements:**

- I understand that once the BHN discloses my health information to the Recipient, BHN cannot guarantee that the Recipient will not re-disclose the health information to a third party. This recipient may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of health information.
- I understand that if I refuse to sign or revoke this Authorization, this refusal or revocation will not affect my receiving services at BHN.
- I understand that this Authorization will remain in effect until it expires or I provide a signed Authorization Revocation form to BHN in person or by mail at the address listed above. The revocation will be effective upon BHN's receipt of the signed Authorization Revocation form. The revocation will not have any effect on any action taken by BHN in reliance on this Authorization before it was rescinded.
- I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize BHN to use and/or disclose my health information in the manner described above.

_____ _____

Signature of Client/Patient/Individual Served Date

**If the individual has a Parent, Legal Guardian or Personal Representative, Provide the following signature:**

_____ _____ _____

Circle one: Parent/Guardian/Personal Representative Printed Name Here Date

Printed Name of Person Who Witnessed Signature: _____

**For Entities Receiving Records that may contain Substance Use Information**

**Prohibition on Re-disclosure of Confidential Information for Client in Alcohol or Drug Abuse Treatment**

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.