Authorization to Release Protected Health Information
From Mental Health, Substance Use, and/or Medical Records

REQUIRED: *Full Name and complete address (Date of Birth or SSN should be completed for verification)*

Patient Name: Jacob Donald Mason Date of Birth: 06 / 20 / 1983

Patient Address: 220 S. IJams st Apt 104 City: Garrett State: In Zip: 46738

Phone Number: (260) 226-9662 Last Four Digits of Social Security Number: 1037

REQUIRED: *Bowen Center location and person/place that can receive information (must include minimum address or phone number)*

I authorize the following Bowen Center location(s):

- ■ **Outpatient Office(s)**
- ■ **Inpatient Psychiatric Unit**
- ■ **Bowen Recovery Center**
- ■ **Bowen Health Clinic**

to disclose the following health information to:

Rachel Marts — Wife — (260) 226-9640

(Name of person and/or organization disclosure is to be made to) *Relationship* *(Phone number)*

220 S IJams st Apt 104 Garrett In 46738 — ( )

(Address of person and/or organization disclosure is to be made to) *(Fax number)*

■ I authorize the exchange of information from the person / organization listed above to the Bowen Center (optional).

Date(s) of Treatment/Services to Release (optional)**:** ■ All dates ***OR*** *(From)*_____ *(To)*_____

REQUIRED: *Select all information that can be disclosed below:*

■ All Records	☐ Psychological Testing Reports	☐ History and Physical Examination
☐ Psychiatry (MD/APN) Progress Notes	☐ Psychiatric Evaluations	☐ Transfer/Termination/Discharge Summary
☐ Therapy/Counseling Progress Notes	☐ Medications/Dosing	☐ Attendance Documentation
☐ Health Clinic Office Visit Notes	☐ Lab/Diagnostic Results	☐ Account / Billing/ Financial Information
☐ Treatment Plans	☐ Immunizations	☐ Other:
☐ Assessments	☐ MD/APN Orders	☐ Other:

REQUIRED: *The purpose of the disclosure authorized above is:* ***[Check ONE specific purpose(s) for disclosure.]***

☐ Progress Reporting	■ To Communicate with a Third-Party Payer/Insurance
■ To Provide Information to Family / Caregiver	☐ For Permission to Return to Work / School
☐ To Communicate with Other Treatment Providers	☐ Other (specify):
☐ To Respond to a Request for Information	☐ Other (specify):

REQUIRED: *If no expiration date or event is listed, I understand this authorization will expire 180 days from date of signature.*

This authorization will expire on: June 9 **, 20** 22 **OR at the end of a specific event:** _____

I understand that certain information in my record may be protected by 42 CFR Part 2 which governs confidentiality of substance use disorder records. 42 CFR part 2 prohibits unauthorized disclosure of these records. **I also understand that by authorizing the release of my records, content of my medical record may include drug and alcohol use treatment and/or diagnosis, infectious diseases including HIV/AIDS, pregnancy test results, genetic test results, and mental health information**.

I understand that I may revoke this authorization at any time by notifying the Bowen Center Medical Records Manager. I understand that if I revoke this authorization, it will not have an effect on information used or disclosed by Bowen Center prior to my action to revoke. I also understand that I cannot revoke this authorization if drug or alcohol treatment has been ordered by the Court as a condition of my sentencing. I understand that I may refuse to sign this authorization and that my refusal to sign may affect my ability to obtain services or my eligibility to receive insurance payment for my treatment.

I understand that upon request, I may receive an accounting of disclosures of protected health information disclosed by Bowen Center (45 CFR 164.528 and 42 CFR part 2.13). I understand that any information disclosed will be the minimum necessary to satisfy the purpose of the request. To request an accounting of disclosures, please contact the Medical Records Manager by mail at P.O. Box 497, Warsaw, IN 46808.

REQUIRED: *Patient or personal representative signature, dates, and relationship of personal representative must be completed*

Jacob D Mason — 6-9-21 — _____

Patient Signature / Personal Representative Signature — Date — Relationship to Patient

_____ — _____ — _____

Personal Representative's Printed Name — Witness Signature — Date

REQUIRED**: For Staff Use Only *(SELECT ONE)*** ☐ Send requested copies now (charges may apply). ☐ File for reference

C655 (R05) (01/01/20)
Authorization to Release Protected Health Information
Bowen Center

For Health Information Management Use Only:

Patient MRN:_____ **HIMS Initials:** _____