Behavioral Health Solutions

Reciprocal Request/Authorization to Release Confidential Records and Information

(All Blanks must be completed)

I hereby authorize **Behavioral Health Solutions, P.A.,** to receive and release information and records with the following person, entity, or facility: **Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**concerning** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Disclosed information shall be limited to **these service dates** \_\_\_\_\_\_\_\_\_ through \_\_\_\_\_\_\_\_\_\_

Disclosed information shall be limited to **the following**:

Complete Record Progress Reports

Intake & Discharge Summaries Medical History & Evaluations

Mental Health/Psychological/Psychiatric Evaluations Developmental and/or Social History

Educational Records Progress Notes, and Treatment or Closing Summary

Verbal Communication Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Use of this information will be limited to **the following purposes**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HIV related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: \_\_\_\_ Do not release HIV related information

\_\_\_\_ Do not release drug and alcohol related information

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations (42 CFR part 2), the recipient may not re-disclose such information without my further written authorization.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, the consequences and implications of their release. This request is entirely voluntary on my part, and I understand that my treatment is not conditioned on obtaining this authorization. I understand that there is potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer protected by the privacy rule. I understand that I may take back this consent at any time, by submitting revocation in writing to Behavioral Health Solutions, except to the extent that action based on this consent has already been taken. This consent will expire automatically upon fulfillment of the purposes stated above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Signature Client’s Printed Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/guardian/representative Signature Parent/guardian’s printed name Relationship

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Witness Signature Witness’s Printed Name Date

Revised April 2020