

BRENTWOOD

BEHAVIORAL HEALTH

A DEPARTMENT OF DEACONESS MEMORIAL MEDICAL CENTER

LABEL AREA

Patient Information			
Patient Name:		Date of Birth: / /	Phone: ()
Address/City/State/Zip:		Dates of Treatment: From: To: Program(s) to Release: ☐ IP ☐ IOP ☐ PHP ☐ Med Mgmt ☐ Assessment Only	
Release Information from (facility):		Release Information to (recipient): Address:	
Attn:		Attn:	
Phone: ()		Phone: () Fax: ()	
Fax: ()		Email:	
How would you like to receive your information: ☐ Mail ☐ Pick-up ☐ Fax ☐ Encrypted Email (Provide recipient address/fax/email above)			
The Purpose Of Release: ☐ Continuum of Care (CoC): Is this consent approved for the exchange of records between this facility & the recipient above? ☐ Yes ☐ No ☐ Disability ☐ Financial ☐ Legal/Court ☐ Insurance ☐ Other Please specify:			
Information to be RELEASED I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information. Please select information to be released by selecting Yes/No:			
Include Substance Use History/Treatment? ☐ Yes ☐ No		Drug/Alcohol Test Results? ☐ Yes ☐ No	
Discharge Order? ☐ Yes ☐ No	Discharge Summary? ☐ Yes ☐ No	Discharge Plan? ☐ Yes ☐ No	Medications? ☐ Yes ☐ No
Psychiatric Eval (CPE)? ☐ Yes ☐ No	History and Physical? ☐ Yes ☐ No	Labs? ☐ Yes ☐ No	Billing? ☐ Yes ☐ No
MD/NP Progress Notes? ☐ Yes ☐ No	Treatment Plan? ☐ Yes ☐ No	Other:	

- Upon presentation to complete a request or pick up records, identification will requested to ensure validity/authority of the receiving party.
- In compliance with the HIPAA Privacy Rule regarding the release of mental health information and the federal confidentiality rules regarding the release of substance use disorder treatment information (42 CFR Part 2), I acknowledge the following:
- (1) This consent is subject to revocation at any time, except to the extent that the facility has taken action in reliance on the patient's prior consent. Revocation for mental health records must be provided in writing; revocation of substance use disorder records may be in writing or given verbally.
 - (2) If not previously revoked, the patient's consent to release mental health and/or substance abuse information will **expire 90 days after the date of this release** unless otherwise noted here: _____
 - (3) This authorization is in effect until the expiration date, event or condition is met and regardless of whether the patient is still receiving services from the provider.
 - (4) If requested, the patient is entitled to an accounting of the disclosures of their protected health information.
 - (5) I acknowledge that choosing whether or not to sign this authorization will not affect my access to treatment, payment for services, enrollment, or eligibility for benefits.
 - (6) I understand that information disclosed or used under this authorization may be shared again by the individual or organization that receives it and, once disclosed, may no longer be protected by the federal Privacy Rules.

_____ Patient/Legal Representative Signature (If POA or Legal Representative, please provide copy of legal documents)	_____ Printed Name/Relationship (if other than patient)	____/____/____ Date
_____ Witness Signature	_____ Printed Name	____/____/____ :____AM/PM Date Time
_____ 2nd Witness Signature (if verbal/telephone consent)	_____ Printed Name	____/____/____ :____AM/PM Date Time

Hospital Staff: Complete an Accounting of Disclosure each time you release records to outside entities. Record each release on form Record of Document of Disclosure (IP-W-006)

Verbal/Telephone Consent should be the exception in extenuating circumstances. Use of the Electronic form in Pulse should be used when feasible rather than verbal consent.

Verbal/Telephone Consent is NOT PERMITTED for patients treated for Substance Use; it is not allowed under 42 CFR part 2 Regulations, authorization must be written/e-signature.

NOTICE TO RECIPIENT: This information has been disclosed to you from records protected by federal confidentiality regulations under 42 CFR Part 2. Federal law prohibits you from making any further disclosure of information in these records that identifies a patient as having or having had a substance use disorder, whether directly, by reference to publicly available information, or by verification of such identification by another person, unless further disclosure is expressly permitted by the individual's written consent or otherwise permitted under 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal law also restricts the use of this information to investigate or prosecute a patient with a substance use disorder for a crime, except as permitted under 42 CFR §§ 2.12(c)(5) and 2.65.