Authorization to Disclose Protected Health Information

I _____ authorize Healing Horizons to ___Obtain From and/or ___Release to **Person or Facility and Relationship to Patient (not patient's name unless releasing to self)**

_____

Email (if known):_____

Phone (if known): _____ Fax (if known): _____

Time Frame *(release does not expire unless revoked or specified)* : _____

I hereby acknowledge that I fully understand the above statements as they apply to me and that my records cannot be disclosed without my written consent except as otherwise specifically provided by law. I understand that by law, I need not consent to the release of this information, but I choose to do so voluntarily.

Please release the following: ___Entire Record ___Progress Notes ___Treatment Plans ___Physical Exam ___Notice of Admission ___ Lab Reports ___Med Notes ___Summary ___Consults ___Psychological Tests ___Other, please specify:_____

This information is needed for: ___Ongoing Treatment ___Aftercare ___Referral

___Other, please specify: _____

Limitations on disclosure (if any):_____

The information to be disclosed may include confidential information as initialed below:

_____Psychiatric Evaluation/Treatment _____HIV Test Results _____Venereal Disease/STI/STD _____Alcohol/Drug Use (past or present)*

*NOTE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

I further release Healing Horizons Behavioral Health, LLC also known as Healing Horizons from all legal responsibility or liability that may arise from this disclosure, and I understand that I may revoke my consent at any time, unless action on this release has already begun in good faith.

Signature:_____

Printed Name of Person signing form and relationship to patient if signing on their behalf: _____

Date:_____

Signature and name of legal guardian if the patient is minor:

_____

HEALING HORIZONS