PINE BELT MENTAL HEALTHCARE RESOURCES Case# _____
Authority to Release / Obtain Information

PART 1:
I hereby give my authorization for: _____ to:
(AGENCY – ADDRESS)
Release information to _____
(AGENCY – INDIVIDUAL NAME &/OR TITLE – ADDRESS)

PART 2: (Initial ALL that apply. You must complete a **separate authorization** form for release of **Psychotherapy notes**.)

Indicate by initialing specific description of information that may be used/disclosed:

When requesting copies of records, indicate specific dates of service needed:
From (month/day/year) _____ **To** (month/day/year) _____

____ Evaluations	____ Summary of Contacts	____ Admit/DC Summaries
____ Case Notes	____ Medications Prescribed	____ Lab Reports
____ Substance Abuse Records	____ Diagnosis	____ Doctor's Orders
____ Prognosis/ Recommendations	____ Treatment Planning	____ Identifying Information
____ Nurse's MAR	____ Other _____	
____ Habilitation/Service Plans/Plans of Care and Related Revisions		

____ **Psychotherapy notes*** **(This is not a compound authorization. If this line is initialed, you may not initial any other item. Release of psychotherapy notes may not be combined with other information to be disclosed.)**

Indicate specific purpose for use/disclosure:

❑ At the request of the Individual ❑ Billing purposes ❑ Emergency Notification
❑ Treatment Purposes ❑ Other _____

I request that payment of authorized health insurance benefits be made either to me or on my behalf to Pine Belt Mental Healthcare Resources for any services furnished by that provider, including physician services. I authorize any holder of medical information about me to release to my insurance carrier or its agents any information needed to determine these benefits or the benefits payable for related services.

I understand that I may revoke this authorization at any time except to the extent that action has been taken by providing a specific request to revoke in writing to Pine Belt Mental Healthcare Resources Privacy Officer. I further understand that this authorization will expire upon _____ and cannot be renewed without my written consent.
(DATE)

I understand that records disclosed may include HIV test results, sexually transmitted diseases and/or alcohol and drug abuse records protected by Federal Confidentiality Rules 42 CFR Part 2. I understand that this authorization is voluntary and my refusal to sign will not affect my ability to obtain treatment. I understand that any disclosure of information carries with it the potential for redisclosure and may no longer be protected by federal law.

❑ I choose to receive a copy of authorization.
❑ I do not wish to receive a copy of authorization.

_____ _____
Individual Receiving Services Date Authorized Representative Date

Attach or include description of representative's authority to act for the individual, if applicable.

_____ _____
Witness/Credentials Date

INDIVIDUAL RECEIVING SERVICES – IDENTIFYING DATA

❑ Request Records

_____ _____ _____ _____
Last Name First & Middle Name Birth Date Social Security Number

NOTE TO PROGRAM RECEIVING THIS INFORMATION REGARDING RE-DISCLOSURE:

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED. STATE AND FEDERAL (42R CFR, PART 2) REGULATIONS PROHIBIT YOU FROM MAKING 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.

PINE BELT MENTAL HEALTHCARE RESOURCES

Consent for Services

Name: _____

Case #: _____

❑ INITIAL ❑ ANNUAL REVIEW

CONSENT FOR SERVICES

I am requesting services from Pine Belt Mental Healthcare Resources. The information which I have provided as a condition of my request is true and complete to the best of my knowledge. I apply for and consent to such psychiatric, psychological, consultation, counseling and/or other therapeutic services as may be recommended by the professional staff. I understand the clinical staff may discuss the services being provided to me, and that I may request the names of those involved. I further understand that my failure to comply with therapeutic recommendations of the professional staff may result in my being discharged. I also understand that only a parent or legal guardian can consent to treatment for a minor child. I further understand that these services are voluntary and I may withdraw from treatment at anytime.

PARENTAL CONSENT: I understand that I will be expected to participate in my child's treatment services at Pine Belt Mental Healthcare Resources. I understand that I retain responsibility for my child while he/she is in treatment at PBMHR and agree to respond quickly to requests for assistance from staff or in the event of an emergency situation. I understand and agree that should I be unable to respond to such a request, PBMHR will take the necessary steps to resolve the emergency situation. I understand that, in the cases of divorced parents, by law the non-custodial parent has legal access to my child's clinical records of PBMHR without the custodial parent's consent.

I HAVE BEEN INFORMED OF, UNDERSTAND, AND HAVE RECEIVED A WRITTEN COPY OF THE ABOVE INFORMATION AND GIVE MY CONSENT TO RECEIVE SERVICES FROM PINE BELT MENTAL HEALTHCARE RESOURCES.

_____ _____

Individual Receiving Services Date

_____ _____

Authorized Representative Date

Relationship to Individual _____

_____

Witness/Credentials Date

Original to Medical Records Pink – Client Yellow – Data Entry