Alliance Health

Consent to Release Personal and Medical Information

This form is used to authorize Alliance Health to share your protected health information to specified entities.

Member information

1

Member's name _____ DOB (mm/dd/yyyy) _____

Record number _____

2

I, _____ hereby request and authorize Alliance Behavioral Healthcare to use or disclose my protected health information to:
Name of member

Name of agency/person/program to who requested use/ disclosure will be made	Client initials

3

Information released may be **verbal**, **electronic**, or **written** and allows for a reciprocal exchange of information. Released data may include records, treatment notes, and other information.

Nature of records to be released:

Please initial beside each applicable document.

- ____ Admission Assessments
- ____ Medications
- ____ Treatment Plans
- ____ Treatment Recommendations
- ____ Psychiatric Evaluations
- ____ Psychological Evaluations
- ____ Progress/Psychotherapy Notes
- ____ Discharge Summaries
- ____ Aftercare Plans/Orders
- ____ Lab Results
- ____ Acquired Immunodeficiency Syndrome (HIV)
- ____ Alcohol/Drug Treatment
- ____ Other: _____

Continued

3 I understand the purpose of the disclosure/redisclosure will be used for:

_____

Information to be redisclosed from: _____

Dates/Timelines of information to be released: _____

My signature below indicates that I understand what information will be released and the need for the information. I further understand that the information to be released may include information regarding drug and alcohol abuse or AIDS/HIV. In addition, information related to drug and alcohol abuse in my records is protected under federal regulations and cannot be released without my written consent unless otherwise provided in 42 CFR Part 2. Once information is disclosed pursuant to the signed authorization, I understand that the federal privacy law (45 CFR Part 164) protecting health information may not apply to recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When we disclose mental health, intellectual and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 CFR Part 2), we must inform the recipient that redisclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws. This consent will expire _____ not more than 365 days from the date of signature.
(specific date or condition)

I understand that I may refuse to sign this release of information form. I understand that Alliance Behavioral Healthcare may not condition treatment, payment, enrollment or eligibility for benefits if you refuse to sign the consent form.

Minor signature (required for SA)		Date (mm/dd/yyyy)
x		

Signature of client/legally responsible person		Date (mm/dd/yyyy)
x		

Relationship _____

Continued

3

My signature below indicates that I understand that I may revoke this consent, verbally or in writing, at any time, except to the extent that action has been taken in reliance on the consent. If you choose to revoke this consent, you may contact the employee working with you or the Privacy Officer as outlined in the Notice of Privacy Practices.

Signature of client/legally responsible person		Date (mm/dd/yyyy)
x		

If revoked verbally, put name, job title and date verbal request was made: