



AUTHORIZATION TO DISCLOSE/RECEIVE CLIENT MEDICAL/HEALTH INFORMATION

Client Initials to FAX, in addition to signature on back.

227 Main Street, Festus, MO 63028-1952

Festus 636 931-2700 FAX 636 931-2139

Arnold Outpatient 636 296-6202 FAX 636 296-0102

Arnold Athena Adol. CSTAR 636 296-6206 FAX 636 296-8907

High Ridge 636 367-0079 FAX 636 677-8400

I, _____ CLIENT'S NAME DATE OF BIRTH SOCIAL SECURITY #

WHO RECEIVED SERVICES FROM (DATES) _____

authorize and request COMTREA COMMUNITY MENTAL HEALTH CENTER to disclose/receive the below specified Protected Health Information (PHI) from my records:

THE SPECIFIC INFORMATION TO BE DISCLOSED/RECEIVED (CHECK ALL THAT APPLY)

- Discharge Summary, Progress Notes, Treatment Plan ITP and/or QTR Review, Social Service Assessment, Educational testing, IEP, transcript, and/or grading reports, Medical/Psychiatric Assessment(s), Critical Intervention Plan (CIP), Transfer Summary, Psychometric testing, including intelligence quotient (IQ) results, neurological testing, or other developmental test results, Billing Information, Therapy (Video), Education (Video), Photo (if for advertising, trade, display, exhibition of or editorial use FMTRT0018), Lipid Panel, Fasting Glucose/Hemoglobin A1C, Disease Management Program Indicators (PCP), Other (be specific)

CHECK WHICH APPLIES: Disclose/release to: (below) Receive from: (below)

TO/FROM: _____ (NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)

_____ (ADDRESS)

_____ (CITY, STATE, ZIP)

If available, Phone: _____ and/or FAX: _____

THE PURPOSE OF THIS DISCLOSURE IS (CHECK ALL THAT APPLY)

- Eligibility Determination, Assessment, Aftercare, Placement, Transfer/Treatment, Treatment Planning, Continuity of Services/Care, Conditional/Unconditional Release Hearing, At Client's Request, Medical Assistance Spenddown Program, Family Therapy/Education, Other (specify)

1. READ CAREFULLY: I understand that my medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of my medical/health information. The protected health information (PHI) in my medical record includes mental/behavioral health information. In addition, it may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable diseases, and/or alcohol/drug abuse. (OVER) Page 1 of 2 FMTRT0039 (Rev. 4/15/2010)

2. Alcohol and drug abuse information records are specifically protected by federal regulations (42 CFR 2) and by signing this authorization I am allowing the release of the specified alcohol and/or drug information, if any, in my records indicated on side one of this release to the agency or person specified above. **Please sign if you are authorizing the disclosure/receiving of alcohol and drug abuse information:**

(Client)

(Parent/guardian or legal representative)

3. This authorization includes both information presently compiled and information to be compiled during the course of treatment at the above-named agency during the specified time frame.

4. This authorization becomes effective on _____. This authorization automatically expires on the following date, event or special condition _____.

5. If I fail to specify an expiration date, this authorization will expire in twelve months.

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so **IN WRITING** and present my written revocation to the COMTREA HIPAA Privacy Officer or Official designee. I further understand that actions already taken based on this authorization, prior to revocation, will NOT be affected.

7. I understand that I have the right to receive a copy of this authorization. **A photographic copy of this authorization is as valid as the original.**

8. I understand that authorizing the disclosure of this medical/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may request **IN WRITING** using the designated HIPAA access form (Request for Access FMTRT0203) to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my medical/health information, I can contact the COMTREA HIPAA Privacy Officer or Official designee for this agency.

THE FOLLOWING APPLIES TO ALCOHOL AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS: Prohibition of Redisclosure: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. [52 FR 21809, June 9, 1987; 52 FR 41997, Nov. 2, 1987]

My signature below acknowledges that I have read, understand, and authorize to disclose/receive my PHI.

SIGNATURE OF CLIENT

DATE

WITNESS

DATE

SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE

DATE

Specify relationship: _____

NOTICE OF REVOCATION

REVOCATION DATE _____

I, _____, (Client) hereby revoke my authorization of this disclosure of information to the agency/person listed above. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

SIGNATURE OF CLIENT

DATE

WITNESS

DATE

SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE

DATE

If you choose to revoke your authorization, please provide a copy of the completed Notice of Revocation (see above) to the COMTREA HIPAA Privacy Officer or Official designee.