



Authorization for Release of Information

Patient Name: _____ Date of Birth: _____

- I authorize Cambia Hills East Bethel to
- REQUEST information from:
 - RELEASE information to:

Provider / Organization: _____
 Address: _____
 Fax #: _____ Telephone: _____

Provide Information via:
 Written Fax Verbal Telephone Secure Email Email address: _____

INFORMATION TO BE RELEASED (INDIVIDUALLY CHECK ALL THAT APPLY):

<input type="checkbox"/>	Psychiatric Assessment	<input type="checkbox"/>	Treatment Plans
<input type="checkbox"/>	Discharge Summary	<input type="checkbox"/>	Progress in Treatment
<input type="checkbox"/>	Discharge Plans	<input type="checkbox"/>	Medical Consults
<input type="checkbox"/>	Psychological Consult/Testing	<input type="checkbox"/>	Acknowledgement of Patient's Access of Service
<input type="checkbox"/>	Alcohol/Drug Abuse Evaluation/Treatment (Requires patient to consent)	<input type="checkbox"/>	History & Physical
<input type="checkbox"/>	Lab Results (CD / Pregnancy lab results require patient to consent)	<input type="checkbox"/>	Information re: HIV/AIDS status
<input type="checkbox"/>	Reproductive Health Information (Requires patient to consent)	<input type="checkbox"/>	Other:

This information will be used for (check all that apply):

- Assessment, Treatment
- Coordination and Follow up
- Education
- Insurance Purposes
- Psychological Evaluation/testing
- Discharge Planning
- Legal
- Other (must specify) : _____
- Acknowledge Patient's Access of Service/Referral

This Authorization remains in effect for one year from date signed, or: _____
 (Specify date, event, or conditions that cause authorization to expire)

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Refer to Cambia Hills East Bethel's Notice of Privacy Practices for instructions regarding how to revoke authorizations or to inspect or receive copies of this information. A photocopy/fax of this authorization will be -treated in the same way as the original. My signature also means that I have read this form and/or have had it read to me and explained in a language that I can understand. Authorizing the disclosure of this information is voluntary and I can refuse to sign this authorization without consequence to my treatment, eligibility for benefits or payment status. Once information is released, as authorized by this form, Cambia Hills East Bethel, its employees and physicians cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

NOTE: PATIENTS MUST PERSONALLY CONSENT FOR ALCOHOL/DRUG ABUSE AND REPRODUCTIVE HEALTH INFORMATION. PARENTAL CONSENT IS NOT VALID. PATIENTS 16 AND OLDER MUST PERSONALLY CONSENT FOR ALL MENTAL HEALTH RECORDS. PARENTAL CONSENT IS NOT VALID.

Signature of Patient Date

Signature of Parent / Guardian Date Name of Staff that obtained and reviewed