Community REACH CENTER supportive mental health

AUTHORIZATION TO RELEASE INFORMATION

MOUNTAINLAND PEDIATRICS

(Please check one)

☐ **Community Reach Center** ☐ **Mountainland Pediatrics, Inc.**

Client Name: _____ ID: _____ DOB: _____

Origin of Authorization: ☐ External ☐ Internal (Reach Center or Pediatrics)

Direction of Authorization: ☐ Outgoing ☐ Incoming

*I hereby authorize (*Information Source Agency): _____

_____

*to release the following information (*Information to Release):

☐ Intake/Initial Assessment
☐ Lab Reports
☐ Social History
☐ Discharge Summary
☐ Psychiatric Eval/Notes
☐ Psychological Evals/Reports
☐ Monthly Summary
☐ Progress Notes
☐ Progress Summary
☐ Drug/Alcohol History/Treatment
☐ Treatment Plan
☐ HIV Status
☐ CCAR
☐ Medical Evaluation
☐ Claims/Billing Information
☐ Other _____

*The information will be disclosed to (*Information Destination Agency): _____

_____

*for the purpose of (*Reasons for Release):

☐ Assessment
☐ Benefits Coordination/Acquisition
☐ Disability Determination
☐ Service Planning
☐ Legal Purposes
☐ Referral
☐ Coordination/Continuity of Care
☐ Payment of Insurance Claims
☐ Other: _____

Expiration Date:_____ (One year from creation, unless otherwise specified)

I understand Community Reach Center and/or Mountainland Pediatrics cannot condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form or not. If the information authorized to be released pertains to diagnosis and treatment of alcohol and/or drug abuse, I understand the information is protected by Federal Law 42, C.F.R. Part 2. I understand that there is potential for information disclosed, disclosed as a result of this authorization, to be re-disclosed by the recipient and therefore no longer protected by the HIPAA Privacy Regulation. I understand that I may revoke this authorization at any time by giving written notice to Community Reach Center and/or Mountainland Pediatrics, except to the extent that action has already been taken to comply with it. Without such revocation, this authorization will expire one year from the date of my signature unless otherwise requested at the onset of this authorization. I understand that I have a right to refuse to sign this form subject to the conditions noted above. If I sign the form, I am entitled to a copy of that signed form.

Signature: _____

Signed by (print name): _____

Relationship to Client: _____

Authority to Sign: _____

Date Signed: _____

Witness Signature: _____

Witnessed by (print name): _____

Date Signed: _____