

Authorization to Release Medical, Mental Health and Substance Abuse Information



Patient name: _____ Date of birth: ____/____/____ Phone: _____	
Address/city/state/ZIP: _____ Program: <input type="checkbox"/> Inpatient <input type="checkbox"/> PHP <input type="checkbox"/> OP	
Please release requested information TO/FROM:	Please release requested information TO/FROM:
	SUN Behavioral Delaware 21655 Biden Ave. Georgetown, DE 19947
Attn.:	Attn.:
Phone:	Phone: 302-604-5600
Fax:	Fax: 302-450-1285
I give my authorization for SUN Behavioral staff to speak with _____ about my treatment and/or benefits/financial information.	
Dates of Treatment being requested: _____	
The recipient of the information released may use it only for the following purposes (must be indicated): <input type="checkbox"/> Continuum of care <input type="checkbox"/> Disability <input type="checkbox"/> Insurance <input type="checkbox"/> Legal purpose/court <input type="checkbox"/> School/educational needs <input type="checkbox"/> Military <input type="checkbox"/> Other – please specify: _____	
Information to be RELEASED : I authorize SUN Behavioral to release and discuss medical records including (any information related to medical, surgical, psychological, social, psychiatric, drug and/or alcohol abuse, diagnosis, treatment, prognosis and/or therapy) therein contained. INITIAL: _____ The information authorized for release may include information about communicable or venereal diseases, which may include, but are not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea, and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome. INITIAL: _____ <input type="checkbox"/> Discharge summary <input type="checkbox"/> Initial psychiatric evaluation <input type="checkbox"/> History & physical <input type="checkbox"/> Orders <input type="checkbox"/> Labs <input type="checkbox"/> Discharge paperwork <input type="checkbox"/> Medication information <input type="checkbox"/> Benefits/financial <input type="checkbox"/> Other – please specify: _____	

How would you like to receive your information? Mail Pick-up Fax Email: _____

- Upon presentation to pick up information or complete an authorization a request for identification will be made to ensure validity/authority of the receiving party.

In compliance with all state confidentiality/privacy statutes/regulations regarding the release of mental health information and federal confidentiality rules in 42 CFR Part 2 regarding release of substance abuse treatment information:

1. This authorization is subject to revocation at any time. Revocation can be given orally or in writing.
2. If not previously revoked, the patient's consent to release mental health and/or substance abuse information will expire 90 days (3 months) after the date of this release unless otherwise noted here: _____.
3. This authorization is in effect until the expiration date, event or condition is met and regardless of whether the patient is still receiving services from the provider.
4. If requested, the patient is entitled to an accounting of the disclosures of their protected health information.
5. My treatment, payment, enrollment, eligibility for benefits will not be conditioned on whether I sign this authorization.

Patient's signature: <i>(includes minors 16 years)</i>	Date:	Time:
Parent/legal guardian's signature: <i>POA or legal representative, please provide copy of legal documents</i>	Date:	Time:
Responsible party phone number: Home: _____ Work: _____ Cell: _____		
Witness signature: _____	Date:	Time:

NOTE TO RECEIVER: The information that is being disclosed is confidential and protected by federal law. The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by federal law and regulations, including HIPAA and 42 CFR, Part 2, which prohibits the receiver of this information from making any further disclosure of same, except with the written authorization of the person to whom it pertains. A GENERAL AUTHORIZATION for the release of medical/psychiatric information is not sufficient for this purpose. Federal laws and regulations restrict any use of the information to investigate or prosecute about a crime of any patient with a substance use disorder, except as provided at §§2.12(c) (5) and 2.65.

STAFF ONLY:

Information disclosed: _____ Staff signature: _____ Date: _____