Release of Protected Health Information

Client Information:

Patient's Name:_____

Patient's DOB: _____

Contact Number:_____

Where information is going/ coming from:

Who is Releasing the Information: **Behavioral Health of the Palm Beaches**

Who is Obtaining the Information (Please provide name, address, phone number, and fax number):

Name: RECORDS DEPOSITION SERVICE, INC. Phone Number: 248-357-3330 Fax Number: 248-357-3337

Address: P.O. BOX 5054, SOUTHFIELD, MI 48086-5054

Email Address: REQUESTS@RECDEP.COM

What information is needed (Please INITIAL next to each item you wish to be disclosed):

Dates of service in treatment: _____

History and Physical_____ Psych Eval_____ Integrated Summary_____ Medical/Clinical Discharge/Transfer Summary_____

Continuing Care Plan_____ Lab Results_____ UDS Results_____ PPD Results_____

Presence in Treatment_____ Progress in Treatment_____

Other: PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST FOR INFORMATION TO BE DISCLOSED

Letter Request _____ If yes, please state what diagnosis you wish to show in the letter (**CIRCLE ONE**):

Substance Abuse Medically Related Condition Full Diagnosis

Reason for Disclosure:

The reason/purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If other purpose, please specify: LEGAL - FOR DISCOVERY BEFORE TRIAL

Right to Revocation:

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Behavioral Health of the Palm Beaches, Inc. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration:

Unless sooner revoked, this consent is valid for **90 days** and will expire on the following date: _____

Form of Disclosure:

Unless you have requested in writing that disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner we deem to be appropriate and consistent with applicable law, including but not limited to verbally, in paper format, or electronically. I understand that if the information is released by fax or electronically that Behavioral Health of the Palm Beaches, Inc. cannot guarantee confidentiality.

Confidentiality Agreement:

I understand that my records are protected under Federal Confidentiality regulations (42 CFR Part 2) published August 10, 1987, and the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. Seq and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions. I understand that if this information is faxed, that confidentiality cannot be guaranteed.

Prohibition of Re-Disclosure:

Any information released as a result of this release is protected by Federal Confidentiality rules (42 CFR part 2). The Federal rules prohibit anyone 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 Client.

_____	_____	_____	_____
Client Signature	**Date**	**Witness Signature**	**Date**