AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Client Name: _____ SSN: (last 4 digits) _____

Client Address: _____ DOB: _____

_____ CID: _____

Client Phone Number: _____

I authorize the disclosure (release) of information pertaining to my health care or payment for health care (Information) protected by HIPAA, and other applicable law, as follows:

Information authorized to be disclosed: (check all that apply)

- ☐ Initial Clinical Assessment
- ☐ Written Summary/Summary Letter
- ☐ Plan of Care(s)
- ☐ Other: _____
- ☐ and Payment Information Billing
- ☐ Progress Summary(ies)
- ☐ Psychiatric Medical Assessment (PMA)
- ☐ Discharge Summary

I authorize my information to be released via: ☐ Mail ☐ Fax ☐ Verbal ☐ In Person

NOTE: I understand that this Information may include information about diagnoses/treatment for alcohol or other drug abuse and HIV/AIDS/ARC.

I authorize the release of this information for the time period from _____ to _____

Purpose of disclosure: _____

I do not want the following information disclosed: _____

Name and address of person(s), facility, etc **authorized to disclose my Information**:

☐ _____

_____

_____

Phone: _____ Fax: _____

Name and address of person(s), facility, etc. **to whom my Information may be disclosed**:

☐ Berkeley Community Mental Health
P.O. Box 1030
Moncks Corner, SC 29461
Phone: 843-761-8282 Fax: 843-761-7308

This Authorization is **valid for one year** from signing unless an earlier date, condition or event is specified here:

_____

I understand that I may revoke (cancel) this Authorization by writing to the facility **authorized to disclose my Information** (above). Upon receipt, I understand that the facility will make no further disclosures of my Information pursuant to this Authorization, except to the extent that such Information was already disclosed prior to my revocation, or if disclosure of my Information is otherwise permitted or required by law. I also understand that Information disclosed by this Authorization may be subject to re-disclosure by the recipient of my Information, unless otherwise restricted by applicable law. I have been given a copy of this Authorization.

_____

Signature Printed Name Date

Authority if signed by Personal Representative (such as: parent, GAL, etc): _____

Signature of **Witness** to the above Signature: _____ Date: _____

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_____ ☐ Approved ☐ Not approved/Reason: _____

Signature/Date of Clinical Reviewer

_____ _____

Prepared By (Complete CSN) **Date** **Sent By** **Date**