ASTRA BEHAVIORAL HEALTH

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ **DATE OF BIRTH:** _____

SOCIAL SECURITY NUMBER: _____ **DATES OF SERVICE:** _____

TO/ FROM: _____ **TO/ FROM:** _____

_____ _____

_____ _____

_____ _____

_____ _____

TYPE OF PATIENT IDENTIFIABLE HEALTH INFORMAITON

_____ **Initial Evaluation- Psychiatrist**	_____ **Initial Evaluation -Therapist**
_____ **Physician progress notes**	_____ **Letter**
_____ **Medication sheet**	_____ **Other (specify below)**

I hereby authorize the release or my protected health information indicated to the individual/ organization listed and understand that "minimum necessary" rule will apply. I understand that my signature on this form will not affect my condition for treatment, payment, enrollment or eligibility pertaining to benefits.

PURPOSE OF RELEASE

_____ **Continuity of Care**	_____ **Vocational Rehabilitation**
_____ **Disability**	_____ **Individual elects not to state purpose**
_____ **Legal Circumstances**	_____ **Other (specify below)**
_____ **Placement/ Disposition**	

I understand that I can revoke my authorization in writing at any time with the exception that the revocation will not apply to information already released in response to this authorization. If not previously revoked this authorization will expire on _____ or 90 days from date signed if not date specified.

PROHIBITION ON DISCLOSURE

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written consent or the person whom it pertains, or as otherwise permitted by regulations. A general authorization for the release of medical 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 patients.

_____ _____

Signature of Patient or Patient Representative **Date**

_____ _____

Relationship to Patient (if representative) **Witness Signature**