RENAISSANCE
BEHAVIORAL HEALTH LLC

AUTHORIZATION TO RELEASE AND/OR EXCHANGE CONFIDENTIAL INFORMATION

Client Name ____Date of Birth___________________________

Social Security Number (last four digits) _______________________________________Phone Number__________________

I, the undersigned, hereby authorize Renaissance Behavioral Health to use or disclose my personal health information and/or confidential information as described below to:

Name of Recipient ____Phone_____________________ Fax_____________

Address (Street) (City) (State) (Zip____

☐ If checked, I further authorize the **EXCHANGE** of information and for the party identified as Recipient above to also disclose my personal health information and/or confidential information to Renaissance Behavioral Health.

Type of Information to be Released/Exchanged:

□ Mental Health Assessments/Evaluations	□ Partial Hospitalization Records	□ Alcohol/Drug Assessment (LOC)
□ Treatment Plan/ITP/Treatment Updates	□ Discharge Summary	□ Alcohol/Drug Treatment Summary
□ Progress Notes	□ Court Reports	□ Alcohol/Drug Treatment Plan
□ Psychological Information	□ Psychiatric Information	□ Alcohol/Drug Progress Notes
□ General Medical Records	□ Employment Records	□ Alcohol/Drug Discharge Plan
(except HIV/AIDS related diagnosis and treatment)	□ School Reports/Records/IEPIMFE	□ Urinalysis/Breathalyzer Results
□ Other (specify):		

Dates of Service to Release (FROM): _________________________________ **(TO):**___________________________

Purpose for Disclosure:

☐ Care/Treatment/Ongoing	☐ Treatment Planning
☐ Assessment/Evaluation	☐ To follow up on a referral
☐ Continuity of Care	☐ Other, please specify: _______________________________________

(purpose for disclosure must be completed prior to processing, e.g., continuity of care, personal use, legal)

I understand and acknowledge that the requested information may contain information regarding physical and mental illness, alcohol and/or drug dependence/abuse*. I also understand that information used or disclosed according to this authorization may be subject to re-disclosure by the recipient and may no longer be protected.

I understand that I may see and copy the information described on this form if requested in writing. I also understand that the provider may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. The health care providers listed above will not receive financial or in-kind compensation in exchange for using or disclosing my health care information.

I understand I have a right to revoke this authorization (in writing) at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. If not revoked, **this authorization will expire one year from the date written below** or on the following date, event or condition (if earlier): ________________________

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I understand there may be charges for the copying and release of information and accept financial responsibility for those charges. I understand and agree that a copy of this authorization shall have the same force and effect as the original.

Signature of Client Printed Name Date

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Signature of Parent/Legal Guardian/ Personal Representative** Printed Name Date

** Prohibition Against Re-Disclosure: This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit 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 C.F.R. 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 information to criminally investigate or prosecute and alcohol or drug abuse client. ** If other than client's signature, a copy of legal paperwork verifying the client's personal representative MUST accompany the request unless otherwise on file with provider (e.g., court appointed guardian, durable power of attorney for healthcare, grandparent power of attorney). Exception: Parent signing for client under the age of eighteen and the County agency holding custody.*

Revocation of Authorization for Release of Information

At the date and time noted below, I hereby revoke permission for Renaissance Behavioral Health to further release information to the above-noted person, except to the extent the program has already acted in reliance upon it.

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Signature of Client/Parent/Legal Guardian/Personal Representative** Date