stresscare
behavioral health

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Director

Authorization to use and disclose protected health information

1. I am completing this form to allow the use and sharing of protected health information about
   Printed name: _____ Date of Birth: _____

2. I authorize StressCare Behavioral Health to obtain, use, or disclose the following information:

   - □ Information from other facilities regarding inpatient or outpatient treatment for physical, psychological, psychiatric, or substance abuse problems. This includes admission and discharge summaries, evaluation reports, treatment notes, or similar records.
   - □ Information from StressCare Behavioral Health, including initial assessments, evaluation reports, progress notes, treatment plans, treatment and discharge summaries, or similar records.
   - □ Information about how the patient's condition affects his or her ability to work or function.
   - □ Billing records
   - □ Complete copy of medical record
   - □ Other: _____

3. Dates of care included: _____ to _____

4. To this person or organization: _____

_____

_____

5. The information will be used/disclosed for the following purposes:
   - □ Treatment coordination
   - □ Other: _____

6. I understand and agree that this Authorization will be valid and in effect until _____. I understand that after the date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization.

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7. I understand that I can revoke or cancel this authorization at any time by sending a letter to the organization listed above and which is to supply this information. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.

8. I understand that I may inspect and have a copy of the health information described in this authorization. If I request a copy of this information, I understand I will be charged $20 for the first fifteen (15) pages and $0.90 for each additional page.

9. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed and no longer protected by those regulations.

_____ _____

Signature of patient or his/her personal representative Date

_____ _____

Printed name of patient or personal representative Relationship to patient

_____

Description of personal representative's authorization