HUMAN BEHAVIOR INSTITUTE
Full Service Behavioral Health

Authorization to Release Protected Health Information (PHI)

Signature must be notarized, if NOT witnessed by an authorized HBI representative.

Name of Patient:	Date of Birth: _ _ / _ _ / _ _ _ _	Social Security #: _ _ _ - _ _ - _ _ _ _
INFORMATION TO BE RELEASED **FROM**:		
Provider/Agency:		Tel. No.: ( )
Mailing Address: Street Address City State Zip		Fax No.: ( )
INFORMATION TO BE RELEASED **TO**:		
Provider/Agency:		Tel. No.: ( )
Mailing Address: Street Address City State Zip		Fax No.: ( )

PURPOSE/S FOR WHICH THE INFORMATION IS TO BE USED – Initial each purpose for releasing the PHI

_____ Continuity of Care _____ Diagnosis and Treatment _____ Coordination of Care/Treatment

_____ Other (Specify) _____

TYPE INFORMATION TO BE RELEASED – Initial each item of information to be released

_____ General Information Letter Only _____ Psychiatric Evaluation Report _____ Progress Report

_____ FMLA / Return to Work Certification Letter _____ Medication / Pharmacy Records _____ Lab or Drug-Screen Report

_____ Other (Specify) _____

TYPE DISCLOSURE – Initial one or both types of disclosure

_____ Written / Document Copy (Note: HBI may charge $0.60 per page to copy patient's records, per Nevada State Law) _____ Verbal / Telephonic / In-person

INFORMATION FOR INFORMED CONSENT

The confidentiality of medical, psychiatric and substance abuse information is protected by State and Federal Statutes, Rules and Regulations including Nevada Revised Statutes and Title 42 of the Code of Federal Regulations. These Statutes, Rules and Regulations require that the individual give informed consent prior to the release of any health/hospital records or information, except as specifically provided for within the Statutes, Rules and Regulations.

Consent to release information will be considered valid only when it states: (1) who will release the information; (2) who will receive the information; (3) the purpose for which the information will be used; (4) what specific information will be released; and (5) when the consent will expire. The consent must contain the individual's or authorized representative's signature and the date of the signature. The authorized representative signing for the client must submit a copy of the legal document(s) granting this authority.

This authorization for the Release of Medical Information waives any and all rights that the individual now has or in the future may have to bring any legal action against the releasing person/facility for any damages caused directly or indirectly by the release of this information or other confidential information. Upon request, the individual will be given a copy of the completed "Authorization for the Release of Protected Health Information."

This authorization is effective immediately and is subject to revocation in writing at any time, except to the extent that action has already been taken in reliance thereon. Otherwise, this authorization expires_____ days from the date of signing (but no longer than 365 days) or upon case closure, whichever occurs first.

I, the undersigned, agree and authorize the RELEASE OF PROTECTED HEALTH INFORMATION pursuant to the specifications identified above. File copy is considered equivalent to the original. I further acknowledge that the information to be released was fully explained to me and this consent is given on my own free will.

_____ _____

Patient's Signature Date
(If minor, must be signed by Parent/Guardian)

Notary or HBI Authorized Signature Date

NOTARY SEAL:

Print Name of Parent/Guardian/
Authorized Representative: _____

☐ **PATIENT REFUSAL TO RELEASE PHI: I have reviewed the above release of information form with the patient and discussed the importance of coordinating care between mental health and medical care providers. The patient has refused to authorize release of mental health and/or alcohol or drug abuse treatment records.**

Signature of Provider: _____ Date: _____