

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Complete all sections entirely. If this authorization is not complete, it may be returned and result in delay in processing. Photo ID required at the time of request.

OFFICE USE ONLY		
Acct/MRN		
Initials		
Pages		
Date		

Patient name:	Date of Birth:	Telephone #:		
Patient Address:  Street City State Zip Code				
Entity health information requested from:				
CCH Mental Health & Substance Abuse CCH: Kid Clinic Behavioral Health				
Dates of service to release: (from): (to):				
Specific information to be disclosed: (Initial Each Item to Disclose)				
Assessment Diagnosis	Psychological Evaluation Psychiatric Evaluation			
Treatment Plan/Summary Current Treatment Update Presence/Participation in Treatment Nursing/Medical Information	Medication Management Information Therapy Notes Educational Information Discharge/Transfer Summary			
Continuing Care Plan Progress in Treatment	Demographic Information Other:			
If Release of Information Includes Psychiatric, Alcohol, Drug Abuse or HIV results, initials are required:				
I authorize disclosure of the above listed information to the following individual or organization:  Self or Name:				
		CD default if not specified		
Information to be disclosed via: (Check one)				
Mail to Address: Street	City Sta	te Zip Code		
Fax to number:	,	'		
Secure email:    Secure email:   Initials are required				
I acknowledge the risks associated with information sent via email that is not secure and CCH is not liable for disclosures misdirected or intercepted in transmission.				
Patient/Patient's Legal Representative Pick Up Records				
Purpose for disclosure:				
(Continuation of care, Insurance, Legal, please specify) – For Personal use if not otherwise stated				
<ul> <li>PATIENT'S RIGHTS:</li> <li>I understand that if this authorization includes disclosure of any PSYCHIATRIC, ALCOHOL, and DRUG ABUSE records, the records are protected by virtue of the provisions of Federal Regulations 42 C.F.R. Part 2. I make this authorization upon the promise that the following notice shall accompany all disclosures of any ALCOHOL AND DRUG ABUSE records made pursuant to this authorization:</li></ul>				
Signature of Detiant/Detiant's Logal Depresentative				
Signature of Patient/Patient's Legal Representative  Date				
Relationship to patient:	Relationship to patient:  Supporting documentation of authority must be provided (Guardianship, Executor of Estate, Power of Attorney)			