Authorization for Release of Protected Health Information

I hereby authorize_____to ☐ Receive from:_____ ☐ Disclose to:_____

the following information regarding my: ☐ Advocate/respite services:_____
specify service dates/appointments

☐ BHRS service:_____ ☐ Outpatient Services: 30 days from time of discharge from BB4B

☐ Advocate Notes	☐ Outpatient Initial Assessment
☐ Monthly Summary	☐ Outpatient Treatment Plan
☐ BHRS Treatment Plan	☐ Psychological Evaluation
☐ Discharge Summary	☐ Psychiatric Evaluation
☐ Demographic Information	☐ Referral/Treatment Summary

☐ Other (please specify)_____
_____

The purpose for disclosing the above information is to be used for: Please check bleow

☐ Continuing Care ☐ Insurance ☐ Legal Matters ☐ Personal Use ☐ Other:_____

I understand that:

- I have no obligation to disclose information from my record and that I may revoke this authorization by submitting a request in writing to, BB4B, 2782 S. Queen St. Dallastown, PA 17313
- Any action already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions.
- Once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.
- BB4B will not condition the delivery of services on signing this authorization.
- Certain protected records such as drug and/or alcohol use, abuse, treatment, or referrals for treatment; HIV information; and mental health services may not be re-disclosed per PA State regulations and laws and/or Federal confidentiality rules.

My signature acknowledges that I have read and understand the contents of this authorization and voluntarily consent to the release of information as stated including release of any records identified below unless I check below to NOT disclose such records. Checking or not checking the box is no indication that such information exists.

Records NOT to disclose:

☐ Drug and/or alcohol use, abuse, treatment, or referrals for treatment

☐ HIV Information

☐ Mental Health Services

My signature also acknowledges that I was offered a copy of this document.

_____	_____	_____
Print Patient Full Name	**Signature Patient/Responsible Party**	**Date**
_____	_____	_____
Patient Date of Birth	**Witness Signature**	**Date**

This authorization shall expire at the end of the year this document was signed unless otherwise specified.

This authorization shall expire at the end of the year this document was signed unless otherwise specified.