AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (BCA)

Printed Patient Name:	Date of Birth:
Address: City: _____ State: _____ Zip Code:_____	Telephone Number: (_____)_____

I hereby authorize Behavioral Care Associates, P.C. and/or _____ to release and exchange written, oral or electronically transmitted protected health information indicated below on the above named individual to:

_____
Provider Name/Organization/Individual

_____
Address of Provider/Organization/Individual

Fax #: (_____)_____

City: _____ State: _____ Zip Code:_____ Telephone #: (_____)_____

E-mail: _____

Including information related to: Mental Health Treatment ___ Substance Abuse Treatment ___ Medical Treatment ___ School ___
Other: _____

For the following purpose: Physician or Health Care Facility Use ___ Legal Use ___ Personal Use ___ Follow-up Care ___
School/Vocational Placement ___ Insurance Determination ___ Continuity of Care ___ Other (Specify)_____

Treatment date(s): _____ to _____
(must include all dates to be disclosed)

Expiration Date: _____
(Should Not Exceed 1 Year)

INFORMATION TO BE DISCLOSED:

Assessment	Treatment/Service	Other
__ Psychiatric	__ Treatment Plan	__ Discharge Summary
__ Psychological	__ Treatment Progress	__ Dates of service
__ Psychological test reports	__ Medication information	__ Lab results
__ Intake	__ Psychiatry Notes	__ Behavior and history of patient
__ Other:	__ Progress Notes	__ Complete copy of clinical record
		__ Other:

HIV Documentation _____(Must Initial)

I understand that:

- **The information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).**
- I have the right of access to inspect and obtain a copy of my protected health information.
- I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing to BCA.
- Revocation will not apply to information that has already been released in response to this authorization.
- Re-disclosure is prohibited unless the person who consented to the disclosure specifically consents to re-disclosure. However, once the above information is disclosed, there is the potential that it may be re-disclosed by the recipient, and therefore may not be protected by the federal privacy laws regulations.
- Failure to provide all required information will not constitute a proper authorization to disclose protected health information and, therefore, my request may not be honored.
- Authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment, payment or eligibility for benefits.

_____ _____ _____ _____
(Signature of patient) (Date) (Signature of Parent or Legal Representative) (Date)

_____ _____
(Witness Signature) (Date)

(Patients l2 to l7 years of age must sign in addition to the Parent or Legal Representative)
(If signed by a legal representative, indicate the relationship to patient or authority to act for patient.)
Fees/charges will comply with all laws and regulations applicable to release protected health information.