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Authorization to Release Information

***Only complete if applicable. ***

Section I – Patient Information

Name:	Member ID:	
Street Address:	Birth Date:	
City:	State:	Zip:
Telephone:	Email:	

Section II – Authorized Designee (to whom the information will be sent)

Name:	Relationship:	
Street Address:	Telephone:	
City:	State:	Zip:

Section II B – I hereby authorize ____
to release my medical record.

Section III – Specific Information to be Released:

□ Please release my Medical Record from (insert date) _______________ to (insert date) ___________________.

□ Please release my entire Medical Record, excluding psychotherapy notes, billing records, and insurance records.

□ Other: (Please explain) ____

____.

Reason for release of information:

□ At the request of the individual

□ Other: ____.

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to mental health treatment, excluding psychotherapy notes.
2. If I am authorizing the release of mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law.
3. I have the right to revoke this authorization at any time by writing to Emerald Coast Collaborative Solutions. I understand that I can revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment will not be conditioned upon my authorization of disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient, and the redisclosure may no longer be protected by federal or state law.
6. This authorization does not authorize you to discuss my personal health information and insurance record with anyone other than the person authorized.

This authorization will be in effect for one year from the date signed, unless you indicate a shorter period below:

Date on which this authorization will expire: ____.

By signing this form, I am confirming that it accurately reflects my wishes. In addition, I have kept a copy of this form for my records. In the case of a minor child, signature of authorized guardian.

Print Name: ____

Signature: ____

Date: ____

If an authorized representative is making this request, please provide your information below and attach certifying documentation of your status as the authorized representative, such as Power of Attorney or Guardianship papers.

Authorized Representative

Name:	Relationship:	
Street Address:	Telephone:	
City:	State:	Zip: