Behavioral Pediatric & Family Therapy Program

AUTHORIZATION TO RELEASE AND/OR RECEIVE PROTECTED HEALTH INFORMATION

Patient Name: ____ DOB: ___________________

I hereby authorize **Behavioral Pediatric & Family Therapy Program** provider, ______________________, to release to or receive from:

Name/Facility: ____
Address: ____
Fax Number: _____________________________ Telephone Number: ________________________

The following information, including identified Protected Health Information, is subject to this authorization:

☐ Academic Records	☐ Billing Records	☐ Communication	☐ Consultation
☐ Discharge Summary	☐ Entire Record	☐ Hospital Records	☐ Lab Reports
☐ Medical Records	☐ Psychiatric Evaluation	☐ Psychological Evaluation	☐ Rating Scales
☐ Social History	☐ Therapy Records	☐ Treatment History	
☐ Other (Please list):			

This authorization will remain in effect for one year from the date signed below or until __________________ (whichever is sooner) and may be received or released in written form, verbally, via telephone, facsimile, electronic mail or other electronic means or any other medium agreeable to both parties.

My signature below indicates that I have read and understood this document. I understand I may revoke this authorization at any time by sending written notice to the person/facility releasing records. Such revocation is not valid if (1) action was taken previously in reliance on this authorization or (2) this authorization was obtained as a condition for obtaining insurance coverage. I understand information released may include reports relating to mental or behavioral health and substance use. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment or my eligibility for benefits.

I understand and agree that this form may be duplicated for the purpose of requesting records. Copies or faxes of this release are to be accepted as the same as the original document. Confidentiality of this information is protected by federal law and no further disclosure is permitted without written consent of the undersigned.

____ ______________________________
Printed Name of Patient | Legal Representative Date Signed

____
Signature of Patient | Legal Representative