MOUNTAIN LAKES BEHAVIORAL HEALTHCARE
Authorization For The Release Of Information

Name_____ Case Number: _____

Date of Birth: _____ Social Security Number: _____

The Medical Record contains confidential remarks furnished by the client, the client's family, the physician, and the staff, as well as all test results which may include mental health records, treatment for alcohol and drug abuse, HIV, RPR, and other communicable diseases, etc. In addition, Federal Regulation 42 CFR, Part 2 and Part 8 prohibits further disclosure of information relating to alcohol and/or drug usage without the consent of the person to whom the information relates and according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160 and 164 Protected Health Information cannot be disclosed without the client's written consent unless otherwise provided for in the regulations.

After giving due consideration to the above statement, I, _____, do hereby authorize Mountain Lakes Behavioral Healthcare to release to, and receive from:

(Agency/Facility/Person)_____

(Address)_____(City/State/Zip)_____

(Phone#)_____(Fax#)_____

the following information as indicated:

- ☐ Medication Record
- ☐ Progress Notes/Reports
- ☐ Diagnosis(s)
- ☐ Evaluations/Assessments
- ☐ History and Physical
- ☐ Emergency Contact
- ☐ Laboratory Results
- ☐ Discharge Forms/Summary
- ☐ Other (specify): _____
  _____
  _____

for the purpose of: ❑ Continuity of Care ❑ Legal ❑ Other (specify): _____

I further agree to indemnify and hold harmless Mountain Lakes Behavioral Healthcare and/or its staff from all liability that may arise from the release of the information herein requested. This release is valid for a period **not to exceed two (2) years** from the date of issuance, unless it is revoked in writing through the MLBH records librarian/designee.

Expiration Date: _____

By providing this Authorization, I understand as follows:

1. that this authorization is voluntary. I may refuse to sign this authorization and my treatment and/or payment obligations will not be affected. Refusal to sign , however, may complicate communication with other healthcare providers or referral;
2. that the health information to be released may be subject to re-disclosure by the recipient of the health information and no longer protected by federal privacy rules;
3. that I may revoke this Authorization at any time by notifying Mountain Lakes Behavioral Healthcare orally or in writing through the MLBH records librarian/designee, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation;
4. that I understand the specific type of information that has been requested and, if known, the benefits and disadvantages of releasing the information and that I may receive, upon request, a copy of this form after I sign it:
5. and that this may include email communication.

_____ _____
Client Signature Date

_____ _____
Parent or Guardian Signature Date

I attest to the identity of the above signature(s):

_____
(Print) Witness Name

_____
Witness Signature Date

If this authorization was obtained through interpretation or translation for the deaf or limited English proficient, please describe:
☐ Sign Language; ☐ Language Interpretation; ☐ Writing; ☐ Other _____

Revised 03/23