MID-ATLANTIC
BEHAVIORAL HEALTH

Authorization for Release of Information

___ MABH is **SENDING** records
___ MABH is **REQUESTING** records
___ MABH to keep request on **file**

This form when completed and signed by you, authorizes Mid-Atlantic Behavioral Health, LLC to release protected information from your clinical record to the person you designate.

I, _____authorize: Mid-Atlantic Behavioral Health, LLC to release to and/or obtain from the following information noted regarding my medical, mental health and substance abuse (if applicable) records for myself DOB:_____ or my minor child _____ DOB_____

___ Entire medical chart
___ Psychological Evaluations/reports
___ Substance Use Information/Evaluations
___ Educational Reports
X__ Letter advising of treatment participation/plan, diagnosis, medications and monthly updates if requested

___ Current functioning information
___ Billing/Attendance information only
___ Other _____

This information should only be Released to/Received from: (PCP) Psychiatrist Therapist School Family Member Hospital Other

Name: _____ Via Phone; _____ Via Fax: _____

Via Mailing Address: _____

For the purpose of: Background Information Evaluation (Continuity of Care) At the request of individual Other_____

("at the request of the individual" is all that is required if you are the patient and you do not desire to state a specific purpose.)

This Authorization is valid until you are discharged from this incident of care or until retracted in writing.

You have the right to revoke this Authorization, in writing, at any time by sending such written notification to the office address provided above. However, your revocation will not be effective to the extent that Mid-Atlantic Behavioral Health, LLC has taken action in reliance on this Authorization or if this Authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that Mid-Atlantic Behavioral Health, LLC generally may not condition behavioral health services upon my signing an authorization unless the psychological services are (i) research-related; or (ii) provided to me for the purpose of creating health information for disclosure to a third party.

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of my information and no longer protected by federal privacy regulations. However, any disclosure of information that pertains to the treatment or diagnosis of drug abuse or alcohol abuse or a referral for such treatment

or diagnosis, and which would identify a patient as an alcohol or drug abuser, permitted hereunder shall be accompanied by the following written statement: "This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."

Any facsimile, copy, or photocopy of this Authorization shall have the same effect as the original.

Patient's signature (if over 14): _____ Date: _____

Parent/Guardian's signature (if patient under 18): _____ Date: _____

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.