Preferred Behavioral Health Group

PO Box 2036, Lakewood, NJ 08701 ~ **Telephone**: 732-367-4700 ~ **Fax:** 732-364-2253

PARTICIPANT'S NAME (Print): _____DOB:_____

I AUTHORIZE Preferred Behavioral Health Group TO *OBTAIN* FROM AND *RELEASE* INFORMATION TO:

_____

Specific Organization/Person

_____

Address

INFORMATION THAT MAY BE RELEASED:

( ) Mental Health/Physical Information: (you must circle "yes" or "no")

Progress Notes **(Yes) (No)**	Assessments **(Yes) (No)**	Diagnoses **(Yes) (No)**
Tx/Recovery Plans **(Yes) (No)**	Psychiatric Evaluation **(Yes) (No)**	Medication Records **(Yes) (No)**
Discharge Summary **(Yes) (No)**	Laboratory Results **(Yes) (No)**	

( ) Drug/Alcohol Treatment Information: (you must circle "yes" or "no")

Progress Notes **(Yes) (No)**	Assessments **(Yes) (No)**	Diagnoses **(Yes) (No)**
Tx/Recovery Plans **(Yes) (No)**	Psychiatric Evaluation **(Yes) (No)**	Medication Records **(Yes) (No)**
Discharge Summary **(Yes) (No)**	Laboratory Results **(Yes) (No)**	

( )_____HIV/AIDS Information
INITIALS

☐ **Other:** _____

REASON: ( )Provide continuity of care ( )Compliance with program ( ) Personal Use ( ) Legal Purposes
( ) Social Security/disability ( ) Insurance/Managed Care ( ) Other (Specify) _____

DATES OF SERVICE: FROM _____TO _____

I understand that my health information is protected under the federal regulations governing the confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2, the Health Insurance Portability and Accountability Act (HIPAA) 45 C.F.R. Parts 160 and 164, and NJ State Privacy Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by the HIPAA Privacy Law.

By signing this authorization, I acknowledge:

1) I have reviewed and understand the Notice of Privacy Practices;
2) I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on the authorization;
3) I have inspected and received a copy of the material to be released;
4) I may request restrictions on how my health information is used and disclosed; and
5) I have received a copy of this authorization and the Notice of Privacy Practices.

Please be advised for **Personal Use** there is a fee of **$1.00** per page for copying and the actual cost for postage. Please be advised you have the right to request a summary of your information. A fee will be established for the summary at time of review.

This form has been fully explained and I certify that I understand its contents. I understand that Preferred Behavioral Health Group may not condition my treatment on receiving my signature on this Authorization.

_____ _____ _____ _____

Participant's Signature | Date | Parent/ Legal Guardian/ Power of Attorney's Signature | Date

_____ _____

Witness Signature | Date

This Authorization Expires: _____

(If no date is written, this release will automatically expire 120 days after the signature date)